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ORIGINAL ARTICLES.

THE FORMATIVE PERIODS OF MEDICAL NOMENCLATURE.

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The present is a time when what may be called the medical dialect of the English language is rapidly growing. It is worth while to pause and consider whether those of the medical profession who are coining new words, and the rank and file who are accepting them and giving them currency, are doing justice to themselves and to succeeding generations among whom the present output of terms will continue to circulate. Let us admit at the outset that it is infinitely nobler to be able to recognize a disease and to treat it skillfully, than it is to be faultless in the choice of language with which to describe the various steps towards the desired end. Never-the-less, it must be remembered that medicine is a profession, not a trade, and that something more is demanded of the physician than the mechanically correct performance of a task. There is much excuse for the Bostonian, who in reply to the question: "What did the doctor pronounce your trouble?" said, "He pronounced it eczéma, and I discharged him immediately." The man who wishes the esteem of his associates must be more than utilitarian, and especially must be correct in details of language, whose use or misuse betrays his standing to every casual acquaintance.

In the infancy of any branch of science, there is an opportunity for the reasonably careful observer, even though he observes superficially, to discover an enormous mass of new facts, and there is a corresponding rapid increase in technical words and expressions. Then there is a period during which facts are correlated and assimilated, while the terminology is revised and improved but without much addition. Again there comes a time when, with more exhaustive methods of research and with concerted efforts to penetrate beneath the surface facts, a second demand is made for a new issue of verbal currency with which to expedite the interchange of newly acquired ideas. No other branch of science has demanded so great an increase of terms as has medicine, and the explanation is easy. In the first place, medicine is not an entity, but the bringing together of all parts of chemistry, botany, anatomy, physiology, microscopy and many other subjects that can have any bearing, practical or theoretical, on the healing art. In the second place, other useful arts and sciences content themselves with a terminology for general principles and a few descriptive structural terms. For example, the botanist uses names that will indicate the classification of a plant and the function and shape of its component parts, but his description fails to reproduce an image of the particular plant which he has in mind. On the other hand, in the matter of anatomy alone, the physician must have a terminology that shall express vividly and exactly the most complex relations of structures, compared with which the boundaries of states and countries, the course of

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rivers and railroads, the location of mountain ranges and other geographical land-marks are of the utmost simplicity. In other medical sciences, like necessity exists for concise and definite expressions. It is not surprising, then, that the average medical student spends at least a year in acquiring a fairly accurate knowledge of the meaning of words.

The first period of word-building for medical science was necessitated by anatomical research, the tendency toward the use of standard preparations of drugs and the recognition of typical groups of symptoms as marking certain diseases. The perspective of time enables us to disregard the long intervals which really separated the efforts of different investigators and to consider the results of several centuries, as simply a step towards the formation of a medical vocabulary. The nomenclature of this period is almost entirely Latin, and fortunately, the educated men were so familiar with that language that their terminology is almost beyond criticism from the grammatical standpoint. It is a curious fact that we have retained the original Latin forms in speaking of bones and muscles, while we have anglicised the names of vessels, nerves and most ligaments. For example, it is customary to say, "extensor communis digitorum," instead of "common extender of the fingers," but we say, "femoral artery," rather than "arteria femoralis."

The question has often been raised whether a nomenclature taken almost bodily from a foreign language is best adapted to the needs of the profession, but there are excellent reasons for uphoding it. It is convenient to employ terms that are unintelligible to patients themselves. Most clinics would be positively brutal if the lecture were given in language that the patient could clearly understand. Note how the disease vulgarly called 'pox' has been in turn spoken of as syphilis, specific trouble and finally lues, in the attempt to keep ahead of the patient's knowledge of terms. Note also that consumption—itself a Latin euphemism has been translated into Greek as phthisis, pronounced successively teesis, tisis and thisis, that these words have been replaced by pulmonary tuberculosis, while since Koch's discoveries have become widely known, all sorts of circumlocution have been used to elude the increasing knowledge of the laity. Another reason for preferring that a scientific nomenclature should be drawn from foreign sources is that familiar words become encrusted with secondary meanings which connect them with other words and tend to conduct the thought away from the object to which it should be confined. The word fibula, for example, suggests to the anatomist the outer bone of the lower leg, and nothing else. Literally, it means a clasp, buckle, connecting pin or bond; but none of these English expressions would be sufficiently definite. The best reductio ad absurdum of the use of a home-made nomenclature is afforded by the Germans. By a curious anomaly, they use side by side a much purer medical Latin than we do, and such verbal monstrosities as heart-bottle for pericardium, slime-skin for mucous membrane and beat-vein for artery. Perhaps, it is because the educated Germans have almost a speaking familiarity with Latin that they are so much less pedantic in the use of it.

But the result is a practical disadvantage to English-speaking physicians, for, while the medical literature of other countries has a technical nomenclature almost identical with our own, that of Germany—the most valuable of all—presents great obstacles to the translator.

An objectionable feature of medical nomenclature, not alone of the first period, but of the present, has been alluded to in these words by Dr. Oliver Wendell Holmes: "If a doctor has the luck to find out a new malady, it is tied to his name, like a tin kettle to a dog's tail, and he goes clattering down the highway of fame to posterity with his æolo attachment following at his heels." It is a very doubtful honor to have one's name go down to future generations to be cursed by successive classes of students who are already overworked to remember necessary facts without being burdened with biographical association. The injustice is often done of immortalizing the name, not of the real discoverer, but of some one who has brought his discovery into prominence, or who has been accidentally connected with it. Moreover, the conspicuous anatomical land-marks, which have been made to serve as monuments to the memory of early dissectors, are such as anyone would notice. The fissures of Sylvius and of Rolando in the brain, can not be said to have been discovered, except in the sense that one

might discover that animals breathe or that the sun rises. No one thinks of naming part of the brain after Burt G. Wilder or W. W. Keen, although either has done more solid work in that part of anatomy than all the older anatomists combined.

The second period of growth in the vocabulary of medicine marks the renaissance of medical science. The systematic use of the microscope developed, almost created, the sciences of histology, embryology and pathology. Ingenious instruments and practical experimentation cleared up doubtful problems in physiology and established pharmacology — the exact knowledge of the action of drugs. Bacteriology opened new worlds of conquest and its practical expression, the use of antiseptic methods to prevent wound infection, made possible the surgery of the brain and abdominal cavity. Critical study revealed a host of new facts and new words were necessary to mark the paths of a multitude of pioneers in every field of medical science. In the preparation of a recent medical dictionary, there was assigned to one man simply the collection of words referring to the modern discoveries in the physiology of the liver, gall-bladder and their ducts and to the new operations on that part of the body. We are almost compelled to designate modern operative methods and clinical discoveries by proper names. It would take a sentence to locate McBurney's point, a paragraph to explain the Argyll-Robertson pupil, a chapter to describe Emmett's operation. Such a nomenclature is photographic in its convenience and accuracy. A less arbitrary and more technical description would be like a painted portrait, more artistic but too wasteful of time and less reliable as to details. Yet it must be hoped that this tendency to use personal names will be held in check and regarded as intrinsically evil.

The question between a foreign and a home-made terminology has been decided in favor of the former by the vote of almost every one who has had occasion to add a word to our already large vocabulary. A few imitators of German embryologists have familiarized us with *mid-gut* and *hind-brain*, but it is significant that most of the new words are of Greek origin and not even of Latin! Why do we say *bacteriology*, *micrococcus*, *pyo-phylactic gastrostomy*, *enteralgia*, *salpingitis* and *neuroma* instead of their Latin equivalents? The reason is not hard to find. English is only nominally a Germanic language; after the first few hundred words necessary in gaining food and shelter, the bulk of our dictionary is filled with words more or less directly taken from the Latin. The most ignorant would recognize nothing stilted or foreign in such words as *city*, *street*, *cause*, *fact*, *add*, *hour*, *school*, *real*, *solid*, *pen*, *table*, and yet all of these are but slightly changed Latin words. Unconsciously, the demand for foreignness, for separation from commonly used expressions, has been so urgent in the case of new scientific discoveries needing names, that not even Latin has been able to satisfy this demand and recourse has been had to Greek. If one could read the future, it would be interesting to know if the next great leaps of medical science will leave their imprint in derivatives from Hebrew or some other language.

History repeats itself. When the English language had assimilated the Latin words which came to it through the Norman conquest and the scholastic writers of the Elizabethan era, the unique phenomenon was presented of a double language having Saxon and Latin equivalents for a great many ideas. So in our present medical terminology we are compelled to have both a Latin and a Greek vocabulary. Thus we say *pulmonary* but *pneumonitis*, *intestinal* and *enteritis*, *cæcum* and *typhlitis*, *vesical* and *cystic*. In many instances English, Latin and Greek synonyms are all in common use, for example blister, vesicant, epispastic; sweat, sudorific, diaphoretic. The facility of the Greek language for forming compounds and supplying prefixes and suffixes has doubtless favored its use in science. Thus we have *ectoderm*, *mesoderm*, *entoderm*, referring to the outer, middle and inner membranes or skins from which the embryo develops; *epidermis*, meaning the covering upon the true skin; *hypodermatic*, describing an injection under the skin; *dermoid* (better *dermatoid*) referring to a tumor whose contents are skin-like; *dermatitis*, meaning an inflammation of the skin; *dermatoma*, a tumor of the skin; *dermatology*, the science of skin diseases; and many others. So an inflammation of any organ is denoted by the termination *-itis* preceded

by the name of the organ; the tumors end in *-oma*; the aches in *-algia*, the discharges in *r-rhœa*. These few illustrations will show how wonderfully plastic the Greek language is—unfortunately it is not always moulded by skillful hands. The standard of classical education has declined since the first period of growth of the medical vocabulary. Whereas the men who bestowed anatomical and pharmacal names could write and speak quite fluently a Latin which was correct in its inflections and syntax, if not in construction, there are at present too many advantages in scientific and practical education to leave much time for the classics. The speaking of either Latin or Greek is an almost unheard of accomplishment, and few of the most erudite, unless actively engaged in teaching these languages, can do more than stumble through a translation of the simplest classical writings. The law of the state of New York, which has been enforced only against those who began the study of medicine after June 13, 1893, requires for admission to a medical college simply a common-school education. One would naturally think that the only objection to the law would be that by making such a requirement, it would be construed as formally approving of the minimum education. On the contary, it was bitterly opposed, not only by some of the prospective students but by many practicing physicians and a few medical colleges, on the ground that it required too much. It was carried only by long continued, hard work on the part of its advocates, the better class of physicians, and was subsequently threatened by amendments which would have delayed its operation and crippled its effectiveness. Yet New York, whose law requires little more than a self-respecting ditch digger would consider necessary, is surpassed by few states in the matter of preliminary medical education, and, astonishing as it may seem, a perceptible improvement has followed the enactment of this law. It must not be supposed, however, that the progress of medical science or the standing of reputable physicians and surgeons can be judged by the educational minimum legalized in this state, or by the greater depths of ignorance permitted in others. Almost without exception, the men of prominence in the profession or those who come in contact with the intelligent part of the community, are well prepared for the work in which they are engaged. They set the pace for medical and surgical progress, while those who would be affected by any possible legal requirements follow as well as they can and are not missed if they drop behind.

Yet the fact remains that the medical profession has not always acquitted itself creditably in following the precedent of deriving its new words from the Greek. In a recent paper on "The Spelling of Some Medical words," Dr. George M. Gould, in the *Medical News* says: "When a word is desired, the modern writer snaps out his Liddell and Scott, gets some words that best suit his purpose and shakes them together in his etymologic basket until they cohere into some sort of unity, not infrequently a very ludicrous one." This sentence pithily expresses the fact that, while the rank and file of the medical profession are unable to do more than memorize arbitrarily the terminology provided for them, the men who create and supply the demand for fresh words, depend for the most part on the half-remembered remnants of an early training. Mistakes are inevitable. For example the word laparotomy, which is almost universally understood as involving an opening into the peritoneal cavity through the middle line, means a cutting into the flanks. Exception has been taken to the word symphysiotomy, which applies to the separation of the innominate bones at the pubes so as to allow a springing apart of the pelvis. The word symphysis means a growing together and should not be used in a new compound in the limited sense of the union of the pubic bones. Yet the alternative suggested, pubeotomy illustrates one of the most glaring sins against literary decency, for it involves the miscegenation of a Latin and a Greek word. The word ovariotomy is another mongrel of this description. It should be replaced by the word oöphorectomy (egg-bearer outcutting) but is retained on account of the arbitrary distinction between an operation for the removal of a large ovarian tumor, and one for the removal of normal and slightly-enlarged ovaries. Tonsillitis and uvulitis are similar misunions of Latin and Greek elements, and should be replaced by amygdalitis and staphylitis for the Greeks used amygdale, whose literal meaning is

almond, for tonsil, and staphyle—a bunch of grapes—for uvula. Perhaps the most flagrant illustration of this kind is endo-cervicitis, whose perpetrator must have had an endo-head-itis. Endo-trachelitis, meaning literally inflammation of the inside of the neck, is at least all Greek, but is objectionable in using the general word for neck in a special sense. Cervical endo-metritis would be preferable to either and not much longer. Many similiar errors might be mentioned. Some of the worst illustrations of the tendency to say in one long word what might better be expressed in a few short ones, are found in the description of gastric neuroses, hyperacid, an-acid, hypo-acid, etc., and in the word uricacidæmia, which is only one step removed from grape-sugar-æmia.

In spite of the errors alluded to in this paper, there is good reason for congratulation that the rapid growth of medical terminology has been on the whole, healthy and symmetrical. To guard against the perpetuation of faulty word-forms, the writer would suggest that some of the International, or even American medical congresses appoint a committee to examine the credentials of new terms, and to report upon words to be discarded or modified. The same end could be reached as well, though less formally, by concerted action on the part of editors of medical journals. No other class of physicians is so widely and recently informed, and no other has the same advantage of a position from which instruction of their colleagues is so readily given and so freely accepted. An editorial committee could recommend changes as wisely as any having the authority of a powerful medical association, and lists of words to be adopted or expunged, could, through the columns of the journals, be given wide circulation. Moreover, teaching by example as well as by precept, would be possible in all parts of the journals that are under editorial control.

DISPUTED POINTS IN PELVIC PATHOLOGY AND SURGERY.

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In the medical profession very many of the old school are unwilling to accept the attested scientific facts of the new school. They are usually men so saturated with old ideas and beliefs that to them every new ideal, every revelation of a new truth in medicine or surgery is a medical or surgical heresy. And then we have the irreverent, iconoclast, the sacred bull amid sacred china, the man whose position is gained and kept for a little while more through the sweat of his jaws than the sweat of his brain. He is not a votary of either the old or the new school, he is a seat of learning all to himself—all his facts are his own—he has no interest in, and nothing to do with other people's facts. These nondescripts are usually mere bundles of little aggravations.

A few years ago intra-uterine applications and tinkering were practically abandoned by a large number of prominent gynecologists, by the men who recognized that gynecology had not reached the dignity of an exact science, that they were yet in their primers as to many needed lessons, to whom the diseases of women were a profound study—not simply a diversion, idle novel reading.

Many of the old methods of procedure were found useless and often dangerous; they were but the out-growth and crude expedients of emergency to be condemned by more enlightened experience. Most authors in discussing disease, treatment and procedure have a few accidents and not a few deaths to cite.

There still are those in the young school claiming to revise procedures without a careful study of their earlier history, who lose sight of the fact that these procedures had been very studiously tested by men much more thoroughly experienced and competent than they, without too much tension upon their modesty, could claim to be.

For awhile the enthusiast, the fresh graduate, critic and reviewer, the new-

fledged, fresh-blossoming gynecological recruit, with few or no experiences, heralds and claims everything for his particular application, method of dilatation, irrigation and drainage. Later he ventures to predict that the uterus will be removed in all cases, an organ that has little to do with the patient's condition in very many instances. Again, early in his trial trips, he washes the septic uterus once an hour, examines all puerperal cases about the tenth day, and makes an application to unhealthy cervix and to the cavity of the uterus.

A few men practically interested in both practical obstetrics and gynecology find such tinkering dangerous. The exceptions commonly seized by disputants are retained placenta or neglected abortions. Nearly all active practitioners have such cases to treat. They are to them not something guessed at, but characteristic symptoms to be promptly dealt with. The general practitioner as well as the specialist fully realizes the importance of emptying the uterus of debris, of all decomposing particles. There is an apportunity in these cases for grave error in diagnosis and treatment.

The absence of one or more periods, pain and prolonged hemorrhage, the passage of clot, shreds of debris or decidua, is not always an abortion, but often an extra-uterine pregnancy, or may be occasionally due to suppuration of tubes and ovaries. I have repeatedly removed a ruptured tubal pregnancy a few days after the curette had been used very freely by a physician mistaken as to the real character of his case.

Men who now deny the mortality following the 'let alone' or palliative treatment of tubal and ovarian disease, a few years ago, while interested in pelvic surgery, made repeated reference to the chronic invalidism, long suffering and numerous deaths in these cases and urged upon the profession through elaborate papers the very frequent occurrence of neuroses, numerous sinuses above and below, and the tedious convalescence, if they recovered at all; and also the impossibility to relieve, cure or save life without resort to surgery. There was a large number of these cases then as now. Now some of these same authors contradict their own teaching. Now they claim that they can be relieved and cured and conception follow, this notwithstanding they know or should know that extensive disorganization has long since destroyed all possibility of conception.

Incisions, tents and other methods of treatment have resulted in a large number of cases of peritonitis and abscess. A small group of cases are recorded as dying of tetanus as a result of the use of the tent.

I have been asked to see patients by men bitterly opposed to operative interference. In spite of their well-directed treatment the patient grew worse, their condition the more alarming. Some I found dying, others very ill. Some are saved by prompt interference, others die before the family or friends have time to consider the matter fully. The physician or physicians make post-mortems in some cases and bring me the specimens, telling me that the operation would have been impossible, that the complications were too great, that the post-mortem was only possible with knife and scissors. This has occurred repeatedly in this city and about it, also in neighboring states. We now save large numbers of women who would die of general infection in a few months under so called conservative treatment, or the application of those delusive devices, which deceive patients and friends by affording only temporary relief.

They are saved by prompt, painstaking and skillful surgery. Delays are wholly responsible for infection, emaciation, renal disease, coughs, phthisis and extensive bowel complications, all of which troubles increase our mortality or augment the risk and complicate the surgery in a number of those cases that change hands and submit to operative interference at the eleventh hour.

The importance of pathological knowledge is vital, for without it it will always be difficult for a surgeon to decide when to act, and when not to act. Again, thorough practical knowledge of diagnosis is essential to determine what line of treatment promises the best results. Without such knowledge or skill there is always danger of a surgeon doing mischief. When he combines ignorance, want of skill, or both, with a fondness for surgery, he is a dangerous man in any community. Take any old salt or tar and he will know and do better. He would intuitively recognize the extent of his knowledge, the limit of his powers, and would keep hands

off and not incur fearful responsibility or invite calamity. These neophytes in surgery illustrate the proverb—"Fools rush in where angels fear to tread!'

While operators continue to give so much prominence to simple pain and tenderness, chill and fever, they will continue to make errors.

It is important to locate the uterus, to determine accurately its relation to accumulations in the pelvis, fixed or movable, lateral or posterior, size, fixation and consistence, and the physical characteristics of lateral masses.

Simple tenderness and pain is misleading.

An occluded tube with retention of blood, pus or water is about always fixed by simple or extensive adhesions. The history of such cases, with the common objective signs, are important and are of great assistance in forming an accurate surgical judgment of what we have to deal with and how to deal with it.

I make the statement without fear of its being successfully controverted, that diseased, disorganized and occluded tubes, with retention, never return to health or perform their physiological functions. The numerous references to case, of diseased or occluded tubes being followed by conception is simply an error in pathology and diagnosis.

I have repeatedly removed a diseased or occluded tube of one side, recognized before operation, and have stated to the patient that probably the removal of the offending side would favor conception—which followed in a number of cases.

I insist upon examinations without the use of an anæsthetic. The coöperation of the patient, is important and sufficient.

In dispensary work the student soon becomes familiar with tubal and ovarian diseases without the use of anæsthetics. He tells quickly what he finds, and on which side the trouble is most marked, and this without complaint of pain on the part of the patient.

Unfortunately, too many operators in the past have been influenced by history, neuroses, hysteria, sterility, back-ache, dysmenorrhœa—by symptoms rather than by objective signs. This is an error, and is the source largely of the disrepute of much of this work, and the confusion that should not prevail. With accurate knowledge of pathology and diagnosis, there will be less wrangling over and less mistakes in our surgery.

We all realize the importance of a more uniform consensus of opinion, and the importance of this society maintaining the principles of sound pathology and surgery. Our medical societies are in a sense operating rooms where object lessons are given. They are the educating and re-educating institutions of our profession. The refinements of surgery and obstetrics are obtained by the concentration, the consecration of time, labor, thought and energy to practical work—by eschewing conservative methods, tapping, incising, fancied ingenious methods, novel contrivences, parade of tables, strained or unnatural positions, terraced sutures and much of our bacteriological lore.

We have done a great work as a society, both in obstetrics and surgical gynecology, a work of great value to science and suffering women. As ardent votaries of a science we have not been groping our way in a spirit of blind faith, we accept only that, the verity of which is confirmed by experience and stands the tests of appeal to experiment and observation. We have grappled with complex problems many of which have not yet been settled to our satisfaction. We may yet be dealing with but elementary truths, but we would deal with them so conscientiously, so studiously as to get down to the deeper underlying truths. We meet in our societies to get at facts, the best logic of our science.

All our triumphs over disease must come of our improved knowledge, our advanced skill in our work. If we have increased the average of human life, it is because we know more and better and promote more strictly and scientifically the conditions of health, than did our forefathers. And if our success in dealing with diseased conditions is greater than theirs, it is because we have used wisely the many lessons they left us as rich legacy, and with vigor and spirit have added to the knowledge they have transmitted. Better know more of nature and the better obey her laws and provide against pestilence in its varied forms. Through our better facilities we have a more accurate and broader knowledge of the laws of hygiene, know more of chemistry, of human anatomy, of physics; know more in every department of medical science. Yet splendid as may

have been and are our facilities, marvelous as has been our advances along all lines, many and arduous will be the steps before the capstone is laid.

Under the compendious title of medicine there is included so very much, that we may well stand appalled at what is before us. We look upon our society as a potential agency, an inestimable aid to our efforts in the immense work. In medicine there are no serene retreats—all its paths are rugged and thick strewn with inviting mysteries; with problems deep as life itself, and as old, which through all our advances we have been solving only in fragments.

Our society has done more than stimulate our efforts, it has awakened higher conceptions of our duties and possibilities; we have gone out from it with the strength, even of our clashes in which it has given us.

COMMUNICATIONS.

UNILATERAL PLEURISY WITH EFFUSION.*

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I have to-day two cases to show, one being a typical and the other an artificial case of pleurisy with effusion. The clinical history of the first is as follows:

M. C., male, aged thirty-seven years; birth-place, Italy; social state, single; family history, father and mother dead; causes of death not known. He has one sister living and well. No history of hereditary disease in the family.

Previous history: When a child he had measles, and later on an attack of chills and fever, but since that time has been in good health until the onset of the present disease. Two years ago he came to this country, but was unaffected by change of climate, and was always healthy up to the present time.

History of present disease: On December 23, 1893, the patient was seized with a sever rigor, followed by headache, intense lumbar and general muscular pains, which continued during the following week. Although unwell and unable to work at this time, he remained out of bed. One week later, December 31st, a sharp pain was experienced in the region of the right nipple, shooting backward to the scapula. On admission, January 3, 1894, the pain in the chest was less severe, accompanied by a dry, hacking cough, with slight expectoration. Respirations were somewhat increased and jerky in character, and some dyspnœa was noticeable, with cyanosis of the lips, eye-lids and finger tips.

Physical examination revealed the following: On inspection, the right side showed fullness with slight bulging of the intercostal spaces, expansion being perceptibly diminished on that side.

On palpating, tactile fremitis was absent over the lower two-thirds of the right lung, being somewhat exaggerated above this. Percussion, with the patient in the erect posture, showed absolute flatness below a line extending from the right nipple in front to the angle of the scapula posteriorly.

On ausculting, the breath sounds were found to be entirely absent over the affected area, and this in conjunction with the other physical signs established the diagnosis of pleural effusion.

To-day, as the patient lies before us, we will begin a systematic examination, by inspection, palpation, percussion and auscultation in regular order. The chest is a well-developed one, the muscles being well-defined. The two sides are symmetrical, with perhaps the slightest degree of bulging to the right. The respirations are still somewhat hurried and jerky in character. The movement on the right side is upward and downward rather than upwards and outwards, as occurs during normal respiration. The apex-beat is plainly visible, being displaced to the left, the pulsation extending to the anterior axilary line. There is no enlargement in the area of cardiac dullness, but displacement to the left has occurred. Several theories are advanced as to the cause of this displacement. It was thought formerly to be due to fluid pressing against the heart, but this has been disproven by the fact that it may, and often does occur with the *beginning* of the peural effusion. Among many explanations is one given by

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Garland, of Boston, which is as follows: The heart lies between the lungs, suspended from the third dorsal vertebra. The lungs being expansive retract on the two sides; that on the side of the pleural effusions has its elasticity impaired, hence its traction force is diminished. The healthy lung being unimpaired retracts and draws the heart to that side. The displacement being further increased by the effusion.

Later on intra-thoracic pressure becomes evident; the elasticity of the lung is destroyed and direct mechanical pressure results. After absorption of the exudate, displacement may be caused by pleuro-pericardial adhesions. Diminished expansion occurs, producing a vacuum and causing a sinking-in on that side of the chest. The intra-thoracic pressure on the affected side is lessened and this, together with the normal atmospheric pressure against the chest wall and the normal intra-thoracic pressure on the sound side, are factors which aid in the displacement. The spleen and liver are often slightly out of their normal position and displaced in a downward direction as detected by palpitation. During health the retractibility of the lungs exerts a traction force on the diaphragm below; this force is destroyed by an effusion filling two-thirds of the chest, or causing considerable intra-thoracic pressure the diaphragm becomes depressed, thus displacing downward the liver on the right side and the spleen on the left. Such cases should be watched with great care.

We will now have the patient sit up. On palpating over an effusion the entire hand should not be used as the boundary line between liquid and lung tissue cannot well be distinguished. Use the tips of the fingers, begin above and proceed downward. In this case I find posteriorly tactile fremitis unimpaired downward to one inch below the angle of the scapula, below that being entirely absent. This is not an absolute sign of effusion, as the entire chest may be filled with fluid and yet some fremitis be present, owing to fibrous bands in cases of chronic pleurisy transmitting vibrations from the lungs to the chest walls. On pressing the finger-tips in the right axilla between the ribs, and the latter tend to converge and do not expand as normally, the respiratory movement is also felt in an upward and downward direction. Percussing anteriorly shows flatness beginning on a level with the nipple and extending downward, with the patient in the sitting position. Percussion over a liquid should always be performed lightly and delicately, the sense of resistance imparted to the fingers often being felt distinctly. Above the nipple line a semi-tympanitic note is produced, showing exaggerated percussion resonance, above the effusion. Skoda's resonance which is a higher pitched note, is only heard when the effusion reaches up to the level of the fourth rib or higher. It also may occur under other conditions. Posteriorly percussion gives below the angle of the scapula a flat note, *i. e.*, one entirely without resonance. In pneumonic consolidation dullness may be obtained, but not absolute flatness, because the alveoli, although filled with exudate may transmit vibrations to the bronchial tubes. Complete dullness is not the same as flatness. In pleurisy with effusion we have absolute flatness; in pneumonia dullness alone may be present. From one to one and a half inches above the level of the effusion in this case, percussion gives a dull note because the lower border of the lung contains less air than normally. This may be caused by congestion or in some instances by œdema of that portion of the lung. Higher up we have exaggerated resonance, the note being elevated in pitch and vesiculo-tympanitic in character. The line of flatness in pleural effusions is not level when the patient sits erect, but gradually rises from the spine toward the axilla, being highest just behind the mid-axillary space, then falls as I proceed toward the sternum. This is an important sign in pleurisy. In a beginning effusion the liquid first comes in contact with the diaphragm, but this cannot be detected by physical examination, flatness on percession being first noticed in the axilla. Some authorities state that the upper line of flatness takes the form of the letter S, but more commonly a curved line which presents its convexity toward the head, is apparent, dullness changing with the position of the patient. In some instances the fluid presses on the diaphragm below and is confined between that muscle and the base of the lung, being prevented from changing its position by the elasticity of the latter. In hydro-pneumo-thorax the liquid moves much more readily because

the elastic force of the lung is lost. In diagnosing a pleural effusion, percussion signs are of the greatest importance, especially dullness changing with the position of the patient, which is apparent in this case. On having the patient lie down we find that resonance extends two inches below the nipple-line. On ausculting we have entire absence of respiratory and vocal sounds below the angle of the scapula, and on deep inspiration and speaking, sounds are transmitted feebly to the ear, although the respiratory murmur is totally absent. No friction rales are apparent because the fluid lies between and separates the pleural surfaces, although absence of pleuritic rales may be accounted for in other ways. The respiratory muscles from pressure may become completely paralyzed and total loss of motion result, as soon as the pressure is removed the muscle reacts and friction sounds may reappear. In the case before us the physical signs and clinical history all indicate pleurisy with effusion.

The subjective phenomena, such as pain in the side shooting to the back, embarrassed jerky respirations, dry croupy cough with scanty expectoration, and moderate amount of fever are not diagnostic. Displacement of the apex beat to the left, with total absence of vocal fremitis, flatness on percussion changing with the position of the patient, are of far more importance and render the diagnosis absolutely certain. But we do not have to deal always with a typical case. Pneumonia or tubercular consolidation may occur as complications. In the latter, evidences of disease are first detected at the apex or apices and progress downward. In the latter also one side is rarely effected throughout, as in the case of pleural effusion. Clinical history also aids in the differential diagnosis: In tubercular infiltration the progressive emaciation, hectic temperature, chronic cough with expectoration of purulent matter, which, when stained and examined microscopically is found to contain tubercle bacilli, all tend to establish the diagnosis without doubt. In croupous pneumonia the elasticity of the lung is overcome, compression of the alveolar structure results and we have dullness, *not* changing with the position of the patient, together with bronchial or tubular breathing and, if in the first stage of consolidation, the characteristic crepitant râle may be heard occuring at the end of inspiration. The attack begins often with a severe chill followed by high fever, extreme dyspnœa, panting respiration, cough with the expectoration of rusty sputa and on the sixth or seventh day crisis occurs, temperature drops to normal, profuse muco-purulent expectoration takes place and the patient enters convalescence. In this disease the physical signs show by inspection limited motion over the affected area, but *no* bulging of the intercostal spaces and *no* displacement of the heart or other viscera. Palpation gives *increased* tactile fremitis and percussion shows dullness, not flatness, which does not change with the patient's position. On ausculting in croupous pneumonia we have bronchial or tubular breathing all over the affected side, together with *increased* vocal resonance and broncophony, which extends to the base of the lung. This never occurs in a pleural effusion because there is a layer of fluid between the lung and diaphragm. In an effusion only when the chest is two-thirds filled with liquid may we get indistinct bronchial breathing over small areas just below the level of the fluid, together with impaired tactile fremitis and diminished vocal resonance. This has been proven by aspiration. Enlarged liver may be mistaken also for right-sided pleurisy, but in this there is no change of flatness varying with the position of the patient and no upper curved line as in a pleural effusion, together with absence of flatness in the mid-axillary region. Again the flatness due to an enlarged liver extends higher in front than posteriorly, which is the opposite in cases of pleurisy. A large abscess on the upper surface of the liver may give an arched line of flatness which, however, does not involve the whole side. In establishing the diagnosis of pleural effusion physical signs are of far more importance than the subjective phenomena.

Now, as regards the etiological factors in a case of pleurisy, in this instance the rigor, headache and severe muscular pains began one week before the development of stitch-like pain in the chest and other symptoms, thus indicating in all probability that the attack was preceded by one of influenza. Another case recently came under my notice, in which the diagnosis of influ-

enza was undoubted, being followed several days later by an attack of pleurisy with subsequent effusion. In this patient there is a history of exposure, but simple exposure does not always precipitate an attack. Very often predisposing causes are present; it is apt to be secondary to chronic alcoholism, chronic Bright's disease, although in this case the urine has been examined repeatedly and found to be normal. Acute infectious diseases also act as predisposing factors in the causation of pleurisy.

Concerning the Prognosis: In simple uncomplicated pleurisy when the general health is good, the prognosis as to life is always favorable. There may be, however, a rapid increase in the effusion, the heart's action or the respiratory functions may become suddenly embarrassed and death result. Relatives or friends of the patient should always be informed as to the liability of this occurrence. In some instances death has occurred suddenly and without apparent cause being demonstrated by post-mortem examinations. Finally, the serum may be converted into pus and an empyema result, thus preventing or retarding absorption, and further complicating the case. In recovery, the membranes are thickened, new tissue is formed and conditions are favorable for the development and growth of the bacillus of tuberculosis. Indeed, often the process is tubercular from the beginning and effusion results secondarily, as in the cases of so-called "tubercular pleurisy," which are very common, or, the process may begin as a simple inflammation and sero-fibrinous pleurisy result.

Treatment of Pleurisy: Simple or sero-fibrinous pleurisy is an inflammation, and not a transudation as occurs in hydro-thorax due to valvular heart or kidney disease, therefore, the first indication is to reduce the inflammation in the pleura, and thus limit the amount of exudation; not to get rid of the liquid. How is this to be accomplished? By local and general measures. If the blood pressure be good, give remedies that reduce the arterial tension as tr. veratrum viride, together with mild diaphoretic and diuretic mixtures. The patient before us is taking a mixture composed of citrate of potash, sweet spirits of nitre and solution of the acetate of ammonia, with additionally bashanis mixture. For the pain, opium is very efficient given in the form of sulphate of morphia hypodermically or in suppositories of the powdered drug or extract. It supports the heart and controls inflammations of serous membranes. Quinine should be given liberally, sixteen or twenty grains daily in divided doses. It also controls inflammation. Locally, mild counter irritation should be resorted to and continued through the fever. Weak sinapisms followed by poultices and protection by means of a cotton-jacket to the chest. When the febrile stage has subsided and the temperature becomes normal, promote absorption by means of moderate purgation together with the administration of iodide of potassium, and some form of iron, preferably the syrup of the iodide of iron. Diuretics and diaphoretics have not in my experience proved very efficient in hastening absorption of the exudate. Five (5) grains of potassium iodide with ten (10) minims of the syrup of the iodide of iron given four (4) times daily may be doubled or trebled varying with the circumstances attending the case. Another preparation much used in this connection is the syrup of the iodide of iron and manganese. But absorption will not always occur under medical treatment and tapping must be resorted to. In aspirating there are certain rules which must be borne in mind by the beginning as well as the older practitioner, both during the febrile stage and subsequently. Only when urgent symptoms are manifested and in cases of the gravest character should aspiration be performed during the febrile stage. When one pleural sac is entirely filled, which can be demonstrated by entire absence of Skoda's resonance and flatness reaching up to the clavicle, aspiration *must* be resorted to. If, during the course of a unilateral pleurisy with effusion, any complications should develop on the unaffected side, in the heart or lung, as demonstrated in the latter by the presence of moist rales, œgophony and impaired resonance, thus indicating œdema; or if the apex beat is displaced to the left and a murmur becomes apparent together with downward displacement of the liver and spleen and development of orthopnœa, aspirate immediately.

In double pleurisies also aspiration should be performed early. How long a

time should elapse after the temperature and active inflammation have subsided before determining to aspirate? If, on making a careful physical examination one week later no evidences of absorption can be obtained, aspirate; on the other hand, if the slighest degree of absorption has occurred at the end of that time, it will often continue uninterruptedly and disappear entirely without interferance. In subacute or chronic cases with effusion, absorption often does not begin until the fourth or fifth week or may not take place at all. In all such cases a good rule is to wait three weeks for the exudate to disappear and at the end of that time, if absorption has not begun, aspirate and remove a small quantity of fluid. This will often be followed by a rapid disappearance of the remainder. The patient before us has had some fever but no complications and as the fluid does not fill two-thirds of the pleural cavity at present there are no indications for aspirating. If after one week, absorption has not begun, some of the fluid will be withdrawn.

NOTE. One week later the internal treatment having been continued, the temperature had dropped to normal, the exudate had begun to disappear and the patients physical condition was much improved, in every respect, rendering aspiration unnecessary.

OIL OF PEPPERMINT IN PULMONARY CONSUMPTION.

CHARLES B. WILLIAMS, A. B., M. D.,* PHILADELPHIA.

Dr. Carasso has recently published (*Deutsche Medicinische Wochenschrift*, No. 49, 1893) a new method of treating pulmonary consumption by means of the continuous inhalation of the oil of peppermint, with the internal administration of the same drug in combination with creasote and chloroform.

Dr. Carasso claims remarkable results in his treatment of cases of phthisis with the oil of peppermint: Not only were cases cured in the first stages of the malady, but even the more advanced stages, where cavities had already formed, were cured. Dr. Carasso states that if there is fever associated with this condition, it will disappear in a few days under this treatment. He ends by citing no less than thirty-nine cases of phthisis pulmonalis in which these remarkable results were obtained.

It has been already demonstrated by Braddon that the oil of peppermint has a bactericidal action, and further, it is a well established fact that chloroform possesses in a marked degree the same properties as an antiseptic. The writer was induced to give the above treatment a trial in a case of phthisis that was well advanced and had resisted almost every form of modern treatment. The patient had been given creasote in increasing doses in combination with cod liver oil, tonics, etc., without any appreciable change in his condition.

For the administration of the oil of peppermint the two following formulæ were prescribed.

℞ Creasoti.....mxcvi.
Chloroform.....mxxx
Olei menthæ pip.....mxcvj.
Spiritus vini rect.....q. s. ad. f℥vj.
M. Et fiat mistura.
SIG. Capiat drachmam unam ter in die, ex pauxillo lactis.

and as an inhalant

℞ Creasoti.....f℥i
Olei menthæ pip.....f℥ij
Tr. conii.....f℥ij.
Alcohol.....q. s. ad. f℥i.
M. SIG. Inhalet gtt x. quarta quaquehora.

Carbolic acid in a somewhat smaller dose or thymol may be substituted for the creasote in this last formula.

In less than one week's time the patient returned and reported remarkable progress in his case since taking the above formulæ. His cough had almost ceased; the expectoration was diminished to a marked degree; a sharp pleuritic pain that had troubled him in his right side for some time past, had entirely disappeared. And there was a return of appetite, so that now the patient ate his meals with a relish that he had not experienced for many months. And finally he was able to resume his occupation as a carpenter at which he had not worked steadily for eight or nine weeks.

The dose of the oil of peppermint mixture has been increased from one tea-

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spoonful 3 times daily, to a teaspoonful every four hours, or four times daily. The patient is rapidly improving under the above treatment.

At the present era in medicine the advocates for new methods of treatment in disease are legion, but their claims for success in nine cases out of ten must be looked upon with suspicion and taken *cum grano salis.* A new drug or a new method of treatment can take rank with the old and classic remedies only when it has been found by repeated experiment and trial to cure or, at least ameliorate, the pathological conditions of the human body for which it has been employed.

Dr. Carasso has claimed great things for the oil of peppermint in phthisis pulmonalis; he cites thirty-nine cases of consumption in all its stages, every one of which have been more or less benefited by this simple drug. And, when we come to think, it has been by the use of simple drugs that the physicians of the good old times attained success in the treatment of their cases, for they used remedies that had been tried for centuries and had been proven by experience and practice to relieve certain pathological conditions. The writer thinks that at least this simple drug should be given a fair trial in order to ascertain fully whether it will effectually combat the invasions of that dread disease, consumption.

PISTOL-BALL WOUND OF THE BRAIN DIVIDING THE LEFT OPTIC NERVE IN THE OPTIC FORAMEN; MENINGITIS; AUTOPSY.*

THOMAS G. MORTON, M. D.

John B., aged twenty-nine years, was brought to the Pennsylvaina Hospital about seven o'clock in the evening of January 5, 1894. Shortly before admission he received a pistol wound of the face; the ball completely divided the right lower eyelid, penetrated the upper maxillary bone, and passed apparently backward and to the left, when its further course could not be determined. The patient was semi-unconscious, but could be roused; he did not seem markedly shocked, but since he had been dringing heavily the symptoms were masked. Temperature was barely 98°, pulse 66, and respiration 24. He gave his name and address, but appeared unable to make further replies. There was moderate hemorrhage from mouth and nose. Breathing had been heavy, but became easier an hour or so after being placed in bed.

On admission the pupil of right eye was found moderately contrcted, but sensitive to light stimulus; the pupil of the left eye was contracted, but was immovably and widely dilated two hours later; an effort was made to determine the location of the ball by an incision below the eye. Examination of the wound by the introduction of the finger led to the conclusion that the orbit was not involved, but that the ball had passed across through the nasal cavity to the left and had entered the brain, and in its course had injured, if it had not destroyed, the optic nerve.

The following day the patient was taken before the class; he was then rational, complained of no pain, and replied to every inquiry. The movements of both eyes were normal; vision was apparently not disturbed in right eye, large and small objects being distinctly seen; left eye totally blind, pupil widely dilated, yet sensitive when light was thrown upon the right.

January 8. General condition less favorable; difficult to arouse; slightly delirious at night; temperature 103°; pupils constantly varying; right more contracted.

10th. Somewhat violent at times; temperature 102½°; requires to be confined in bed.

11th. Able to reply to questions, sat up in bed. The following examination was made by Dr. Thomas H. Fenton:

"*Right eye.* Pupil about 6.5 mm., somewhat oval horizontally, feebly sensitive to light stimulus.

"Optic disk fair size, somewhat oval vertically, rather dull in color, well out-

*Read before Phila. Acad. of Surgery, Feb. 5, 1894.

lined, margins slightly elevated; fundus rather deep in color; veins very full; arteries somewhat contracted; media clear, so that all details are possible, but general definition defective owing to the slight haziness of cornea; tension normal.

"*Left eye.* Pupil 4mm., not absolutely immobile but not responsive to light stimulus, either with right eye open or closed; somewhat sensitive when right is covered. Optic disk fair size and shape; definition very good; the temporal half is leaden white, devoid of vessels; all vessels contracted on the nasal side of disk and throughout fundus, which has distinctly anæmic appearance; arteries very much contracted; no structural change except just below disk margin, where there is a small horizontal hemorahage 1mm. in size; media perfectly clear; tension normal; eyes in good position; movements normal. Large ecchymosis, bulbar conjunctiva temporal side, observed today."

16th. Patient has rapidly failed, delirium has continued since last report, and he died at 11.10 with a temperature of nearly 104°.

Post-mortem.—The ball entered the superior maxillary bone just below the orbital rim, about one-eighth of an inch to the inner side of the infra-orbital foramen, passing upward, backward, and to the left through the nasal cavity, fracturing the ethmoid and vomer; the orbital plate of the frontal bone was fissured, destruction of left olfactory, breaking through the body of the sphenoid, tearing away the lesser wing on the left side, completely severing the left optic nerve in its groove or foramen; the ball then passed into the left frontal lobe, where it was found just inside a large wound which continued upward and slightly backward and penetrated nearly to the upper surface of the brain.

The brain tissue in and around this wound was softened and degenerated. Several fragments of bone were carried in the brain substance by the ball, which was flattened and very rough. Evidence of suppurative meningitis existed over the entire base of the brain, and the vessels of the pia mater were markedly congested.

REMARKS BY DR. FENTON.

The case as reported by Dr. Morton is not only interesting because of its extreme rarity, but because it affords an opportunity for conjoined study by the surgeon and the ophthalmologist. Nearly all the references obtainable by a careful search of the literature of *wounds* of the *optic nerve* have been studied, and no case exactly parallel has been found. The question of main importance in this part of the record is, as to how far the extent of the injury can be determined and the foreign body located by an examination of the eyes. That such examination somewhat lessened the obscurity in this case seems reasonable. The patient gave a very credible history of previous good vision in the left eye, which yet was found to be completely amblyopic; while the right, in which some disturbance was to be expected, was practically uninjured. A valuable observation made by Dr. Claytor, the resident, is that on the date of admission, January 5th, at 7 P. M., the pupils were of equal size, and that two hours later the right was contracted and the left widely dilated. The eyes were in good position, the associated movements were normal, no loss of motility, no impairment of sensibility, no surface anæsthesia, no hypernæsthesia. Externally, then, there was nothing but the inequality of the pupils, and the ecchymosis of the bulbar conjunctiva in the left to serve as a guide. It must be remembered that the first examination which could be secured was made five and a half days after the injury. It is reserved for the opthalmoscope to give some suggestion as to the scope of the injury and the direction taken by the bullet; more especially because the atrophy, though not complete, was clearly of recent origin, and not the result of long-standing disease. This suggested that there had certainly occurred, as stated at the time, a hemorrhage into the sheath, and, in all probability, a nearly complete division of the nerve. This view was further confirmed by an examination made on the morning, and again on the evening of the 14th, when it was found that the vessels were still more thread-like and the optic disk paler; right pupil oval as before, 6 mm., left 8 mm., circular. It seemed quite certain, therefore, that the point of injury was quite well back, because, as Fuchs says; "It is only when the optic nerve has been injured so far forward that the central vessels are at the same time divided that characteristic opthalmoscopic symptoms

can be made out at once. In such cases there develops immediately after the injury a picture analogous to that of embolism of the central artery. The arteries of the papilla and the retina are bloodless, and the retina soon becomes clouded—a sign of its death." As then expressed, the examination of the eyes externally and internally seemed to favor the surmise that the track of the bullet was to the left and upward, rather than backward and downward, although the precise route and the extent of the injury occasioned by its passage could not be determined. The occular state certainly did not suggest trouble at the base. An interesting case strengthening this belief is furnished by Benson: "Perforating gunshot wound of the right eye. Immediate collapse of ball—followed in a few seconds by complete amblyopia of the left eye. Opthalmoscope showed a simple athrophy with no thickening of the coats of the vessels, which were very small. * * * There were no symptoms of central mischief."

It is evident that the most important appearance in this case was the peculiar condition of the optic nerve and retina; although the disturbance of the pupils seemed to indicate some injury to the oculo-motor and the fifth nerve. This lent more credit to the case because, as Mitchell says (*Injuries to the Nerves*): "Muscular injuries of the mortor nerve of the eye which do not at once involve loss of life are rare." It is interesting to add that this quotation is taken from an account given of a case seen by the author in consultation with Dr. Morton, in which he, the author, states that the case stands alone in the history of oculo-motor-nerve esions.

A FURTHER COMMUNICATION UPON THE USE OF CARBOLIC ACID.

OSCAR H. ALLIS, M. D., PHILADELPHIA.

One of the results of my article on "Carbolic Acid," read before this Society in October last, was the reception of two practical and interesting letters upon the same subject from physicians who were no strangers to the valuable services attainable by the proper use of the drug. By permission of the writers I am permitted to present their views before the Society.

The first is from Dr. D. H. Brodnax, Brodnax, La.

"In 1868 I came near shooting off my right wrist. The explosion of the gun was so near that it set fire to my shirt. I was, therefore, suffering not only from a severe traumatism, but also from a painful burn. Dr. Hart, of Pickins, dressed the wounds and burns with a mixture containing ten per cent. carbolic acid in linseed oil. The pain ceased, and I slept well all night. Dr. Hart remarked as he dressed my wounds, 'You are the first man in Mississippi to have a wound dressed with carbolic acid. This was twenty-five years ago, and during that time I have never found a drug to take its place. Other so-called 'antiseptics,' have been given a trial, and that is all.

"No part of a physicians experience is more valuable than when he is the sufferer; and you will pardon me if I add one other personal experience. In 1880, while soldering a broken tin pipe, I accidentally spilled same molten solder on my hand between the thumb and first finger. I flirted off the mass, about the size of a silver dollar, which took the skin with it and caused most intense suffering. Near at hand stood a bottle of carbolic acid. I took the bottle, and with the cork wet with the drug, smeared the fresh wound. This was too slow business, so I inverted the bottle and poured some of the acid into the wound. As if by magic all pain disappeared, the burning and smarting stopped, leaving a sense of refreshing coolness. What surprised me quite as much as anything else was my ability to finish the work that I had begun with as much ease and unconcern as if nothing had happened. The cure, too, was prompt and uneventful.

"My next case was a woman seventy-five years of age. She had burned the upper surface of the foot so severely by upsetting scalding water, that when the stocking was removed the cuticle came with it. The poor woman was in great agony when I arrived. The raw surface was fully eight inches long by five inches wide. I

took a feather which I had picked up as I entered the yard, and with it spread the undiluted acid over the entire raw surface, and extending the application over the parts adjoining and which were less deeply burned. In a few seconds all pain ceased, and the patient remarked, 'It feels as if cold water was being poured over it.'

"The third application was to a child three years old, who, while at the breakfast table, pulled the coffee-pot over, emptying the contents into its bosom. Its clothing was removed, leaving the neck and breast of the child denuded. I immediately applied the officinal strength of carbolic acid to the raw surface, covering also the unbroken blebs with the same. Pain ceased almost instantly, when the child permitted me to cut the blebs and paint them without a wimper.

"My after-dressing to the burnt surface is very simple. I apply directly to the raw surface absorbent cotton, which I retain in place with a bandage. This is the first and usually the only dressing, for when it comes off the part is healed.

"As my practice has been of a general character, I have not had a large number of any one class of cases, but think that I have used the carbolic acid in at least twenty burns and scalds. Two more cases that I recall may interest you. A man was burned by a jet of steam that skinned the forearm from the elbow to the wrist. The carbolic acid was applied, and with the same result, the man remarking, 'I thought I was in for two weeks, but I'll be at work again in the morning.'

"A child, one year old, got a live coal in the bottom of its shoe. The burned area was the size of a five-cent piece, and deep. The child was nearly frantic with pain. I dipped a small piece of cotton into the pure acid and pressed it into the burned hole. I *counted* eighteen seconds, when the child stopped screaming, and, looking at me, said, 'It done; it has stopped hurting.'

"I always keep the pure crystals on hand; and to them add, when I require their use, just enough water to dissolve them, possibly ten per cent. This is strong enough to remove the skin from healthy parts. I do not add the water to dilute the acid. When it is deliquesced, as it sometimes is, I use it without any water.

"While, probably, carbolic acid has no rival in its curative action upon burns and scalds, its medicinal influence does not stop here. In sciatica I have found that the hypodermatic injection of from five to ten drops of a solution of twenty drops of carbolic acid to the ounce of water carried down to the seat of pain produces almost instant relief. So, too, in carbuncles and boils, I take a solution of from twenty-five so fifty drops to the ounce of water and inject deeply into the inflamed area a couple of drops in three or four places. On the following day the injection is repeated if necessary. The inflamed area is covered with a little absorbent cotton soaked in:

℞

Carbolic acid	gtt. xxx.
Tannin	ʒiv.
Aquæ	ʒij.

By this means the morbid process is arrested and resolution promptly takes place.

"I treat gonorrhœa with injections of the strength of ten drops of carbolic acid to the ounce of water, giving also *per orem* two or three drops three times a day. Cure usually in about three weeks.

I have never but once used it upon a freshly-cut surgical wound, as Dr. Gardner suggests. In this case I removed a urethral caruncle of large size, and which was an obstacle to micturition. After clipping off the growth with scissors taken from the lady's work-box, I immediately applied undilute acid to the cut surface. The pain, smarting, and hemorrhage ceased promptly.

In regard to the use of the deliquesced carbolic acid in burns, Dr. Gardner confirms what Dr. Brodnax claims for it. He says:

"While the Alabama and Chattanooga Railroad was in process of construction, from 1869 to 1874, I, as surgeon to the road, had between five and six thousand men under my care. Among the injuries burns and scalds were frequent and often serious. These would vary in size and depth, sometimes involving the extremities and a large portion of the trunk. One foreman, in particular, had a large part of the back and a lesser amount of the front portion of the trunk, with portions of the legs, seriously burned. On removing the clothing, large portions of the skin came off with it. His condition was lamentable in the highest degree. Morphine was freely

administered internally. On the bed upon which he was to recline, clothes soaked in carbolized oil were laid. Where the blisters were unbroken the carbolic acid applied with a view of toughening the skin. Where blebs were present these were treated to a thin coating of the pure acid, and let alone. The relief was very great It is the only treatment that I have ever used in burns and scalds."

The following is from the pen of Dr. C. J. Cleborne, Medical Director of the U. S. Naval Hospital, Chelsea, Mass. He writes:

"I believe I was the first to use carbolic acid in full strength (Merck's crystals) in buboes, boils, carbuncles, and glandular swellings generally, and can add confirmatory experience of twenty-five years to that of Dr. Gardner's. I made free openings in suppurating buboes, squeezed out the pus, applied the liquified acid to every part, dressed it with zinc ointment, and often in a fortnight the sailor was discharged to duty.

"On one occasion my apothecary on shipboard, who was greatly enthusiastic over the curative effects of carbolic acid upon buboes, injected, upon his own responsibility, nearly a drachm of the melted crystals into the urethra of a marine. *That gonorrhœa ceased then and there*, but that apothecary did not show himself to the marine for a week, for there was murder in his eye! No stricture nor other evil followed, but I should not fancy it would be the favorite injection. I have often used it as an analgesic, painting it over a felon before cutting. Dr. Ashhurst, I think, has used alcohol on cut surfaces after operations; but I think Dr. Gardner must be the first to use *carbolic alcohol*—for that is all it is—so extensively.

"Carbolic acid in a dilute form is readily absorbed. I have detected hydrochianine in the urine of women using carbolic soap in vaginal injections, the urine turning very dark in some cases; but in its full strength I do not think it is ever absorbed. I have used it in hydrocele and in cysts about the neck and jaws, and in no instance have I noticed constitutional effects. The prompt albuminizing of tissues with which the acid comes in contact renders them incapable of absorption. I regard it as the mildest and most superficial of all escharotics. I have known carbolized oil to prevent the healing of ulcers and wounds. In such instances I believe it cuts down the healthy delicate granulations, acting as an irritant. It is often useful as an application in chancroids and venereal herpes. I prefer it to the tincture of iodine as an injection into small cysts. I have injected two drachms into cysts about the jaws. In such, any excess may be slowly absorbed, but I have never known ill effects from its use."

I wish to call special attention to the use of liquid carbolic acid, full strength, or, if the crystals are used, only enough water added to make a solution, as an immediate application to all varieties of burns. Neither Dr. Brodnax nor Dr. Gardner claims originality.*

POTASSIUM PERMANGANATE, AN ANTIDOTE TO MORPHINE, is the burden of Dr. William Moor's report to the German Clinic, New York. He demonstrated his faith by taking three grains of morphine and immediately swallowing a solution of four grains of permanganate of potassium in four ounces of water. No effects of the morphine could be discovered. The antidotal property of permanganate of potassium for morphine, snake poison, etc., has long been known. Condy's fluid, a solution of permanganate of potassium was recommended years ago for these conditions. Dr. Moor's experiments have been tried in Chicago; unfortunately the dog which was the subject, refused to become affected, even after the hypodermic injection of six grains of morphine but continued lively and frisky, until the patience of the investigators was exhausted.

Soothing Syrup Without Opium.

℞ Ol. anisi .... *m* xxv
Alcoholis..... ʒij
Fl. ext. valerian..... ʒj
Ol. menth. pip..... ..... *m* xv
Tinct. camphoræ..... ʒij
Fl. ext. glycyrrhizæ..... .... ʒij
M. Sig. Shake the bottle. Dose, one-fourth to one-half teaspoonful in water, repeat as needed.

—*The Doctor.*

Scrofula

℞ Ol. morrhuae..... ʒiij
Syr. calcis lactophosphat..... ʒij
Syr. ferri iodidi..... ..... ʒiij
M. Sig. Teaspoonful three or four times daily.

—*Ex.*

---

* Dr. Charles W. Dulles, author of "What to do First in Emergencies," and who is familiar with the literature upon the treatment of burns, says that he has "never seen any mention of the use of the undilute acid as a topical remedy."

TRANSLATIONS.*

THE TREATMENT OF CHRONIC CONTRACTIONS OF THE KNEE AND HIP-JOINT BY TENOTOMY OF THE TENDON OR MUSCLES.

The author, J. Wahncau, reports eight cases treated by him, in which the contractions were due, respectively, to articular rheumatism, disseminated cerebro-spinal-sclerosis, infantile paralysis, spinal origin muscular atrophy, acute poliomyelitis, and traumatic inflammation of the knee-joint. In chronic cases of extensive myopathic contractions, in which the extension apparatus, or all other local treatment remain unsuccessful, Schede has practiced a free transverse separation of the shortened soft parts, his method being as follows:

For instance, in a case of shortening of the lower extremity, he makes a longitudinal incision on one side of the tendon of the biceps, the other, along the tendon of the semi-membranossus and semi-tendinosus at the point where they seem most tense in the popliteal space, of about seven or eight centimetres. All the tense soft parts between these two incisions, minus the large blood vessels and nerves, are then divided transversely, and the knee stretched, the wound dressed antiseptically and kept moist, which usually heals in the space of three to four weeks.

The author emphasizes the importance of moist dressing in wounds of tendons, this affording the most favorable means for repairing defects in such structures. In all the above mentioned cases, of which the author gives a detailed account, the results were all that could be wished. In three cases tenotomy was performed at five different places, the results being perfect. —*Centralb. für Chirur.*, 1894. —W.

STRUCTURAL CHANGES IN THE KIDNEY FOLLOWING NEPHROTOMY.

Dr. A. Barth reports (*Archiv. f. Klinisch. Chirurg.* Bd., 46, Heft II., p. 418) the case of a woman, æt. 31, who was presumably suffering from tubercular disease of the right kidney. Exploratory nephrotomy was performed September 14, 1892. The expected changes in the pelvis or parenchyma of the kidney were, however, not found, the incision in the kidney was closed as also the external wound. There was continued rise in temperature, accompanied with violent pains in the region of the right kidney; the urine contained bacilli of tuberculosis. Thirty-four days after the first operation, October 18, 1892, the right kidney was extirpated; it was deeply imbedded in hard callous-like tissue. The microscope showed a thin cicatricial line extending into the hilus, where the incision had been made. In the centre of the kidney close to the cicatricial line, a wedge-shaped necrotic deposit was seen, and on the opposite side of this line a narrow zone of absolutely dead tissue could be defined.

On the line of demarcation between the living and dead tissues there was a distinct line of interstitial growth.

The larger necrosed portion, almost triangular in shape, still retained many of its canals and cells apparently intact, but not susceptible to coloring matter; in the outer zone the parenchyma was dead. The stroma and cells were surrounded by a fatty detritus. The cells were leucocytes, undergoing retrograde changes, some seemed filled with fatty globules. Isolated leucocytes were found in the uriniferous tubules and the glomeruli. A third zone consisting of an increase in connective tissue formation, in which there was also destruction of the canals and glomeruli, either homogeneous or granular. Here could be seen columns of cells seemingly connected with the uriniferous tubules, and suggesting the formation of new canals. Some of the destroyed tubules and glomeruli had retained their outer

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators W. A. N. Dorland, M. D., M. B. Werner, M. D., and F. H. Pritchard, M. D.

form, but seemed filled with fine tissue, not unlike connective tissue.

In the center of the wedge-shaped necrotic deposit, the vessels and canals were filled with a fine fibrinous network. Some isolated crystals of haematoidin were found in the destroyed blood-vessels.

The author justly calls attention to the similarity between this picture and cases of infarction due to emboli. The cases are the same with one exception, that in his case it was due to an injury of the artery, instead of an embolus.

In spite of this experience, the author still insists that the incision made by him is the best, since all others will lead to still greater destruction of blood vessels.

—W.

TUBERCULAR PLACENTA.

Lehman demonstrated at the Berliner Medizinische Gesellschaft (Berl. Medical Society) a placenta, which showed tuberculous changes in the villi of the chorion. The deposit was of gray, partially yellow color, transparent, round and contained tubercle bacilli.

The patient was highly tubercular, and gave birth to a child, which died on the tenth day without showing any symptoms of tuberculosis. This may prove a solution of the question as to infection of the fœtus.—*Deutsche Medizinische Wochenschrift.*

—M.

ŒDEMATOUS SWELLING OF THE PREPUCE ACCOMPANYING THE USE OF ANTIPYRINE.

Dr. Freudenburg reports: Male, thirty years old, took seven-and-half grains antipyrine for headache. No relief; an hour later felt a burning sensation in the urethra and considerable itching of the prepuce, and behind the scrotum. Considerable swelling of the prepuce and the glans were noticeable.

Freudenburg administered the same patient some four weeks later and again gave seven-and-a-half grains antipyrine to verify the supposed effect of this drug. Two hours later, the same symptoms as stated were observed.—*Centralblatt fuer Klinische Medigin.*

—M.

GANGRENE OF PENIS FOLLOWING INFLUENZA.

Dr. Devriant observed a case of influenza, which developed gangrena penis on the fourth day of the disease. Patient, forty-one years, had a very severe attack of influenza. On the second day he noticed a redness and swelling of penis. On the third and fourth day buboes were developed. Patient denied positively venereal infection or traumatism. Neither gonorrhœa nor chancre present. Urine was clear, no albumen or sugar being present.

The treatment consisted of elevation and leadwater solutions for the pain.

On the fourth day a large gangrenous bulla developed on the point of the glans, which extended in a few hours over one third of the penis. On the following day (fifth) the gangrenous mass was removed. This mass extended to the fibrinous sheath of the corpora cavernosa. The urethra was healthy, the veins in the gangrenous mass were filled with thrombi. Thorough removal of the gangrenous portions and antiseptic dressings cured the patient in eight weeks.—*St. Petersburger Med. Wochenschrift.*

—M.

Urticaria of Children.

℞ Chloral hydrat.,
Comphoræ pulv.,
Acaciæ pulv.,.....aa 3j.
Triturate till liquefied, then add
℞ Cerat. simpl.,..... 3j.
M. Sig. Apply topically.

—*Canada Med. Record.*

THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.

INALTERABLE FOWLER'S SOLUTION.

Dr. Brautigam (*La France Medcal*, No. 2, 1893) proposes the adoption of Traube's formula in the preparation of Fowler's solution. It yields an unalterable preparation. One gram (fifteen grains) of arsenious acid is dissolved, by boiling, in five c. c. (ʒj¼) of caustic potash, the solution is then diluted by adding thirty grams (ʒj) of water, forty grams (ʒj¼) of alcohol and five to ten grams (ʒj¼—ʒijss.) of essence of peppermint. Finally, enough alcohol is added to make 100 gms. (ʒiijss.) The dose is from ten to fifteen drops in twenty four hours.

STATIC ELECTRICITY IN CHOREA.

Dr. R. Verhoogen (*Revue Internationale de Bibliographie*, No. 22, 1893) reading the results which Dr. Courjon of Lyons, had obtained with static electricity in the treatment of two cases of chorea, in children where the disease had but recently appeared and where the writer had obtained almost immediate and lasting results, determined to try it. He had under his observation two typical cases, and, from his results he can completely confirm Courjon's recommendation. It succeeded where the usual means of treatment failed, and though the number of patients treated was small, he thinks it deserving attention.

STRYCHNINE IN SNAKE BITES.

Dr. Smith (*Australasian Medical Gazette*, No. 11, 1893) reports the case of a boy ten-and-half years, who being bitten by an extremely venomous serpent, was cured by subcutaneous injections of strychnine, even after bloody vomiting, a semi-comatose state following convulsions, collapse and small pulse announced approaching death. The effect of the injections was immediate, for the next day he was up and about and able to work.

GRINDELIA ROBUSTA.

Dr. Jasiewicz (*Le Mercredi Medical*, No. 49, 1893) states that this drug is easily taken in any preparation and it may be prescribed in elevated doses, yet it is best to give it in broken doses, on account of its slight toxicity. A very large dose at one time might be fatal. It causes a mild sensation of warmth in the stomach, slows the respiratory and cardiac movements, dilates the pupils and induces sleep. It has a slightly acrid and pungent taste. It is especially indicated in respiratory neuroses, asthma, especially the spasmodic form, whooping cough and similar coughs, nervous cough, hay fever and emphysema. It acts favorably in acute bronchitis, but it must be taken for considerable time. In chronic bronchitis it is less satisfactory. In whooping cough antipyrine acts better as a sedative though grindelia may be administered, on the contrary, much longer, without fear of unfavorable consequences—a considerable feature in a disease requiring so long treatment. Though it decreases the violence of the cough it does not shorten the duration of the disease, for this disease is not a respiratory neurosis but an infectious disease, requiring antiseptics, antispasmodics and tonics.

In asthma it is more active. It calms the dyspnœa, prevents its return, but does not ultimately remove the disease. Here the iodide of potash is most efficacious in this latter respect. It is a precious remedy in spasm and has been found of value in stridulous laryngitis. Externally, Dr. Bardet has found it of service in vaginitis, genito-urinary catarrhs and burns. Dr. Bocquoillon recommends it in the itching of skin diseases. There is a certain resemblance, therapeutically, between it and belladonna.

SULPHIDE OF SODA IN LEAD POISONING.

Drs. Peyraud and Quinquad (*Le Mercredi Medical*, No. 49, 1893) have experimented on animals and persons, poisoned by lead, in order to determine the best means of assisting the elimination of lead from the organism. The good effects of the chloride of soda were already well known to them and they can confirm this action from their experiments but they find the sulphate to exercise a still more energetic influence. It acts the same upon mercury as lead.

RHEUMATISM IN CHILDREN, AND ITS TREATMENT.

Prof. Jules Simon (*Le Bulletin Medical*, No. 97, 1893) states that in children it chiefly appears between five and thirteen

years, and contrary to what he observed in adults, attacks only one joint. The swelling is more pronounced and not only the synovial membrane but all the tissues around the joint are inflamed. The fever is generally only moderate and rarely reaches the height that is seen in adults. In the morning, sometimes it falls one to two, or even two and a half degrees. Endocarditis and pericarditis are observed more frequently than in adults but do not assume the dangerous character; often lasting two or three days, and even if peristing for some time rarely being followed by the consequences seen in later life. In children compensation is much easier. It rarely becomes chronic. Muscular rheumatism in children chiefly affects the sterno-mastoid muscle and the contiguous parts, often simulating an attack of tonsillitis, and is mostly associated with inflammation of the atlanto-occipital articulation, which is characteristic of youthful age. Yet other regions as the upper arm, thigh and buttocks may also participate. In acute articular rheumatism, rest in bed is above all things indicated, then warm aromatic beverages and milk. To the affected joint and its surrounding region, the following liniment may be carefully applied:

Extract of bellandonna.....	2 gms.	(grs. xxx.)
Oil of hyoscyamus.....	15 "	(3iv.).
Oil of chamomile.....	30 "	(3j.)

Over this apply a layer of cotton batten, so that the joint is in a permanent sweat bath. Internally, the best remedy is the salicylate of soda, but if it is not tolerated, try the sulphate of quinine. Do not begin immediately with large doses. The first day one may prescribe seven and a half grains, the next day twenty-two grains and so on up to forty-five, or at the most fifty grains. On the second day after the maximal dose, gradually decrease to a daily dose of twenty-two grains. Even after recovery—in children it lasts, as a rule, fourteen days—continue the drug for eight to ten days at twenty-two grains per diem. If the disease becomes chronic, employ massage and electricity, the constant and weak current. Internally, together with tonics, one should employ the tincture or some other preparation of colchicum, which is of great service in the chronic form. For eight days, give ten drops of the tincture, before going to bed, then discontinue it for eight days and so on to complete recovery. In the intervals, one may use the iodide of potash, which, of itself, is not as active as colchicum. He warns especially against sending such children to the sea-shore or damp regions.

SALT WATER IN ACUTE ANEMIA.

Dr. Ostermann (*Muenchener Medicinische Wochenschrlft*, No. 2, 1894) reports that in Martin's Private Hospital, in Berlin, he has obtained very favorable results with infusions of salt water in acute anemia. Hypodermic injection is especially recomended. The needle is introduced into the subcutaneous tissue in the vicinity of the mammary gland or in the intraclavicular region, the water allowed to flow in from an ordinary irrigator, with continuous massage in the direction of the needle. In this way one may inject in a few minutes from two to three hundred grams (six to ten ounces) and repeat the injection, in a short time, if necessary. At the same time one should employ stimulants, ether, musk or camphor, subcutaneously.

If the heart be especially weak, one may aid it with artificial respiration. The solution is to be injected, prophylactically, in every anemic person where an operation is necessary and, obstetrically, in placenta previa.

FREQUENTLY RECURRING EPISTAXIS.

Prof. Cozzolino (*Bulletin Medical*, No. 101, 1893) rejects the use of the perchloride of iron and advises the employment of a solution of trichloracetic acid, in distilled water; 1 gm.: 30–40 gms. of distilled water. A tuft of cotton is wound around a splinter of wood and the solution applied directly to the cartilaginous septum whence the hemorrhage generally comes. In order to prevent the disagreeable sensation of burning, one may add a little cocaine or better tropacocaine. The remedy acts rapidly, a scab forms on the cauterized spot which falls off and the wound heals.

GARGLE FOR SIMPLE TONSILLITIS.

In *Revista Clinica Terapeutica*, (No. 12, 1893) the following formula is recommended in simple tonsillitis:

℞

Borax,.....	6gms. (3jss).
Tinct. of Benzoin,.....	15gms. (3iv).
Rose Water,.....	ad 130gms (3vss).

Gargle frequently with this mixture.

BACTERIOLOGICAL NOTES.

STREPTOCOCCUS IN PERNICIOUS ANÆMIA.

An interesting case of pernicious anæmia and its causes is reported by Fischel and Adler(*Zeitschrift f. Heilkunde*, No. 4, 1893). A patient who had contracted a slight wound in the left heel some months previous to the examination was admitted to treatment on account of anæmia. The blood corpuscles were abnormal in number and other symptoms were present which led to the diagnosis of pernicious anæmia which resulted in death. An hour before death the blood for the first time was examined for bacteria and chains of streptococcus were discovered. A few minutes after death cultures were made from the blood. The *post mortem* examination confirmed the orginal diagnosis. The cultures developed streptococci which resembled *streptococcus pyogenes* very closely, It was pathogenic for mice. The author thinks that the anæmia was the result of the streptococcus which gained entrance at the time of injury of the foot and which had developed a chronic case of septicæmia. The argument is that the toxic products of the germ causes a deterioration of the blood which enables the streptococcus to enter the circulation and produce the somewhat rapid fatal results. To support this view they experimented with sterilized cultures of the streptococcus on rabbits which resulted in the diminuted red and white corpuscles and, finally death, of the animals. The author lay much stress upon the importance of bacteriological examination of the blood early in the course of such of troubles. They also point out the difference in the nature of the disease which they studied, the deterioration of the blood corpuscles, and the septicæmia usually produced by these bacteria.

THE ETIOLOGY OF PERITONITIS FROM PERFORATION.

The exciting cause of peritonitis even when induced by perforation of the intestine has been attributed to many causes, but the doubt that is entertained concerning the exact factors gives the results of certain definite investigations of the subject considerable interest. Barbacci (*Centralblatt f. Allgem. Path.*, Bd. IV., No. 19) gives the results of his study of fourteen cases of peritonitis produced by perforation. In addition to these cases he has made several experiments on animals. The conclusions which he has reached are of special interest. They are as follows:

1. Cultures made from the peritoneal exudate in cases of peritonitis from perforation in man, develops usually only a single species of bacteria—*bacillus coli communis*. Occasionally, however, diplococcus lanceolatus capsulatus (Frænkel) can be shown to exist in the exudate by the inoculation of mice and rabbits.

2. By artificial perforation of the intestine in the dog an affection precisely similar to that following the perforation in man may be induced.

3. In both man and dog only one organism, *bacillus coli*, is found in cultures from the peritoneal exudate although the latter may be found to contain very varied organisms.

4. After the entrance of the fæcal matter into the peritoneal cavity, the various bacteria therein contained develop equally with *bacillus coli* during the early stages of the inflammation which is induced. But subsequently they die, whereas *bacillus coli* continues to thrive and thus is susceptable of further cultivation.

5. No efficient cause for the death of microbes can be assigned. Experiments do not support the theory that they succumb to *bacillus coli* in the struggle for existence.

6. In a number of cases one finds bacillus coli in the heart blood of persons who have died of perforation peritonitis. In others it is not to be found there; and this, coupled with the fact that it is absent from the blood of the dog when the necropsy is performed shortly after death, renders it probable that, in the first men-

tioned cases, the entrance into the blood stream took place *post-mortem.*

7. The diplococcus lanc-capsulatus is never found in the exudate in cases of the dog, and as it is also absent in many of the human cases, one may conclude that this organism does not play an important part in the pathogenesis of the perforation peritonitis.

8. As regards the course and termination of the disorder much depends upon the amount of time which has elapsed since the preparation. If the aperture of communication can be closed inflammation of the peritoneum may be checked, even though far advanced, and complete recovery will then be secured.

10. The intestinal gases which pass into the peritoneal cavity with the feces play a not inconsiderable part in orginating and perpetuating the peritoneal inflammations.

11. The latter is due to two co-operating causes, each of which is by itself self imperative, namely, its extravasation of feces and of gas and the development of the germs contained in the former. The inflammation is perpetuated by the continuous irritation of the extravasated matter.

12. Death in cases of peritonitis from perforation is due to an intense intoxication of the organism that results from absorption of the fluid and gaseous contents of the bowel and the toxic bacterial secretions.

DIPHTHERIA.

The importance of pseudo-diphtheria bacillus, its relations to the Klebs-Loeffler bacillus, and the efficiency of antiseptic treatment of diphtheria have all been matters of careful investigation, and still remain questions of interest. Kossel, *Deutsch Med. Wochenschrift,* No. 46, 1893) has brought together the results of certain recent investigations in these lines which are quite interesting. It is now generally considered that the pseudo-diphtheria bacillus is only an attenuated form of Loeffler's bacillus, and that it may regain its virulence. The virulence of the diphtheria bacillus depends on the alkaline reaction of the boullion in which it is cultivated, on the age of the culture, on the size of the animal, and on the place of injection. The production of the diphtheria poison dependent at first only on the original virulence of the culture and the alkalinity of the medium in which it is cultivated. Oertel differentiates two kinds of membrane: (1) small greyish, white or yellow points of of deposit, which later become confluent and spread to adjacent parts; and (2) in addition to (1) an œdematous swelling of a tissue, which is dull in appearance and remains smooth. This dullness extends into the deeper parts, and the epithelium, also assumes an opaque color. When this is detached it bleeds, this is malignant diphtheria. Leucocytes may accumulate in the deeper layers of the tissue and produce necrotic areas which may ultimately rupture on the surface.

Treatment: Antiseptics are applied in the first case in the form of spray (2 to 6 per cent carbolic acid) every two hours. In the latter case caustics should be avoided. Decomposition of the membrane should be guarded against. The surface should be swabbed with carbolic solution after the removal of the membrane. The internal use of potassic chlorate is not recommended, but mercurial salts may be tried.

Klebs has endeavorod to find a specific treatment (*British Medical Journal*, 1893, p. 1070, Nov.) but Kossel thinks that in the absence of bacteriological proof some of his cases might not have been true diphtheria. Klebs answers this, and states that they were genuine cases and adds that he has since treated forty new cases with only four deaths.

[Some time ago Dr. Robert Reyburn, of Washington, D. C., published an article in the *Medical Record*, in which he reported several cases of successful treatment of diphtheria by the use, locally, of a strong solution of mercuric chlorid. He used as high as 1 to 500 solution. His cases, were in part, demonstrated diphtheria, as the Klebs-Loeffler bacillus was found in the membrane. He administered mercury salts as well as applying it locally, but he attributed his success to the antiseptic treatment.—*Ed.*]

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SATURDAY, MARC 10, 1894.

EDITORIAL.

THE EFFECT UPON THE NURSLING OF THE MOTHER'S DIET.

The feeding of infants on artificial foods is a growing evil for which, although they inveigh against it, physicians are in a large degree responsible. Efforts are made to explain the evil away on such grounds as the desire of the mother to avoid the inconveniences of her natural duties, or of changed conditions of life causing inability to furnish food in sufficient quantity, if at all, or of deficient quality of the mother's milk, or other conditions, for all of which the mother is responsible. These conditions do exist in a greater or less degree, but aside from actual and acute disease, the maternal conditions may be tersely summed up in the statement that the mother is unwilling to make the sacrifices necessary if she performs her duty to her child. The responsibility of physicians lies in weakly conceding to the patient's desires, in place of strenuously insisting upon the mother's every effort to carry out the provisions of nature.

In these days of milk-foods, prepared foods, substitutes for mother's milk, etc., etc., mothers do not understand that the nature which provides organs for bearing children, also provides organs for nursing children, and intends that these organs should be for use rather than ornament. She does not realize that the products of modern science at best, are but poor substitutes for the products of nature. If the physician would insist upon the mother performing her natural functions despite her assertions that she 'cannot nurse the child,' 'never could nurse her children,' 'didn't have milk enough,' 'nipples too small or too tender,' or 'milk left her in two or three months,' etc.—if the physician should insist, and the mother persist, both would be surprised to find that long abused nature would still be willing to do her proper work.

Patient endurance of discomfort, persistent effort and proper food will eventually demonstrate the ability to nurse their infants, in nine out of every ten mothers who assert the necessity, in their individual cases, for "bringing up the baby on the bottle." And that, too, without scouring

materia medica for imaginary galactagogues, and likewise to the very great benefit of both mother and infant.

During his six years' service at the Preston Retreat, Dr. Joseph Price gave the medical profession, through that institution, some most valuable object lessons in obstetrical science.

There was no secret in the methods used to make that institution the model maternity of the world so far as professional results are concerned. His guiding principles were *care*, *cleanness*, and *common sense*. The strictest supervision of every detail, scrupulous practical cleanness and not so much of theoretical cleanliness, and simplicity in all matters, enabled him to complete his service with a mortality record never equalled in private or public maternity work.

It was a law with him "to allow the mother to bear her own children," and it was equally the rule to require each mother to nurse her own infant during her stay in the institution. So very rare were exceptions to this rule necessary, that a nursing bottle could not be found in the entire institution. The patients in the Retreat were in no respect an exceptional class, save in the fact that so large a proportion of them were ill-nourished and impoverished in physical health when they entered the hospital — conditions which would entitle them to claim inability to nurse infants. Another fact of interest was noted, namely, that many mothers, who while in the house furnished abundant food supply and left the institution with thriving babies, would, after leaving, put the baby on the bottle as a matter of personal convenience, and in a surprising proportion of such cases, would lose the babies within a few months.

The moral to be drawn is that almost every woman who can bear a child can nourish it. Attention to the body functions, generous supply of simple, nourishing food, and early and persistent efforts to establish and develop the mammary secretions were the only methods used to secure these results.

In general practice the physician is too apt to give up the contest too early or to rely upon some form of stimulant to the glands, which eventually proves delusive if not injurious. It is a common practice to administer alcoholic beverages in the form either of ale, beer, or porter to nursing women for the purpose of increasing the milk supply. Beyond question these articles are capable of doing much injury to both mother and child, and their indiscriminate employment for such purposes should be interdicted.

Dr. J. W. Byers, in the *Annals of Gynecology and Pediatry*, has made some very pertinent remarks on this subject. He says: "The truth is, in this practice of using alcoholic drinks the profession has followed the customs and whims of the laity, rather than the usual process of instructing and leading the latter. That there are conditions and circumstances in which the administration of malt liquors is of decided benefit to both mother and child, no one will undertake to gainsay. But that they are indicated in every instance of deficient lacteal secretion, or that the exigencies of the case ever render necessary their use to the extent as is commonly employed, none can maintain or justify. The promiscuous and general practice of using malt liquors by nursing women is irrational, does a vast amount of harm, and often causes disease in the suckling. We know that the mammary gland, for all practical purposes, may be considered as an organ possessing functions of a twofold or mixed character, namely, secretion and excretion. Under normal physiological conditions the first of these processes is in almost exclusive operation, though, is shown by experiences, the slightest alteration in the condition of the organism, whether of an emotional, medi-

cal, or dietetic character, may so change this secretion that it becomes to all purposes and effects an excretion, and an innocuous, healthy pabulum for the child is converted into a deleterious or poisonous substance."

"Experience is very general in showing that the milk fats and albumins, in increased proportions, have a decidedly injurious effect upon the digestion of the infant when taken into the stomach in excessive quantities. From a number of experiments conducted by Zaleski he found these substances in the milk in excessive proportions whenever the mother had partaken of alcohol. In each case where the mother was tested with malt liquors, the fat and albumen appeared and caused more or less disorder and distress of the digestive apparatus of the suckling. These deleterious influences, however, were not the worst. Analysis of the milk further revealed the fact that it actually contained alcohol and the micro-organisms peculiar to malt liquors; that the liquor drank by the mother actually passed out *in toto* through the mammary gland and on into the child's stomach, and there produced all the phenomena incident to digestive disorders and febrile disturbances. These facts point to the belief, and support the attitude, that the mammary gland under certain conditions exercises the function of an excretory organ, and that under some circumstances it becomes nothing more than a filter through which the food and drink taken by the mother, passes directly into the stomach of the child. This being true, we are in a position to understand and appreciate the importance of the relation of the diet of the mother and the well being of the child. When we prescribe alcohol for the mother, we at the same time do so for the child."

"The diet of the mother is a stage in the milk-producing process, and the milk she produces, is, in every instance, the result, and only the result, of the food of which she partakes. If it be improper, unsuitable, or contaminated, the milk will express this in a proper ratio. In the case that beer or ale is administered it will find this outlet, and while it does not evidence deleterious influences to the extent of producing the worst results in the form of either colic, indigestion, or diarrhœa, in every instance its effects are present, and these are always among the possible results of its use. The effects of fat and albumin, when present in breast milk in excessive proportions, in producing evil effects on the child are too well recognized to dwell upon. That the more severe of stomach disorders, gastro-intestinal catarrh, enteritis, or even cholera infantum, are due to these substances, as a result of the abuse of malt liquors in the mother, is certain, though such is not generally admitted or recognized."

"Take care not to advise a woman, whose milk supply is reasonably full, to resort to beer or other liquors in order to increase it. Always impress upon them the increased risk to the child incurred by using them."

Change of Meeting Place.

In view of the fact that the largest and best hotel in Gettysburg was burned a short time ago and will not be rebuilt in time for the meeting of this Society, it was deemed best after consultation with the Board of Trustees to change the place of meeting; and as the Philadelphia County Medical Society extended an invitation for this Society to meet in Philadelphia, this was accepted.

The Medical Society of the State of Pennsylvania will, therefore, hold its Forty-fourth Session in Philadelphia, May 15, 16, 17, and 18, 1894.

H. G. McCormick, *President.*

Wm. B. Atkinson, *Secretary.*

ABSTRACTS.

IMPERFORATE ANUS, WITH RECTO-VAGINAL FISTULA IN A PATIENT NINTEEN YEARS OF AGE.

Mr. Henry Thompson reports a case of a patient, who was sent to the Hull Infirmary on September 25th, 1893. The mother stated that the girl was a week old before the nurse found out that there was any malformation. When five or six weeks old, Mr. Thompson, of Beverly, "tried to make a proper opening," but failed to do so. When fourteen months old she was brought to the Hull Infirmary and examined. Nothing was done, but the mother was advised to bring her again when fourteen or fifteen years old. During the whole of her life of ninteen years, the girl has never had control over defecation, but during childhood she had relief without the administration of an aperient, although the mother stated that up to admission to the Hull Infirmary she had never known her to pass a "formed" motion. Seven or eight years ago she began to suffer from attacks of "sickness and purging." At first these attacks only occurred at intervals of three or four months, but latterly there had been only, as a rule, an interval of a month or so.

During these attacks she had stercoraceous vomiting and constant passage of fluid motions. The patient had never menstruated, but had always been an active intelligent girl. On admission to the hospital she appeared more like thirteen instead of ninteen years; there was an absence of an anus, its site was marked by a cicatrix.

The hymen was absent, the vagina capacious. Just within the vagina on its posterior surface, a round aperture could be felt communicating with the rectum, which was felt to be loaded with a huge accummulation of fæces, which probably extended through the whole of the large intestine. On October 7th, the patient was anæsthetised, the lower bowel cleared, and the following operation performed: A combination of Mr. Whitehead's for severe hemorrhoids and Lawson Tait's splitting oporation for ruptured perineum. The rectum being plugged through the vaginal fistula. A verticle incision was made from the apex of the perineum to the tip of the coccyx and continued down to, but not at first dividing, the mucus membrane of the rectum. The rectum was then freed for some distance from its attachments so that it bulged into the upper part of the wound like the end of a sausage. Anteriorly each side of the vaginal fistula was split and the posterior wall of the vagina was dissected up from the anterior wall of the rectum for some distance beyond the upper end of the fistula.

After continuing the original vertical incision through the mucous membrane of the lower end of the rectum seven sutures were inserted, attaching the edges of the edges of the freed rectum to the edges of the skin, so as to form an anus. These were not tied until the vaginal fistula had been sutured. Commencing at the apex of the vaginal fistula, a small threaded, right-angled needle was passed through the mucus membrane on one side from before backward, then catching the other side from behind forwards, so as to bring together the anterior one and a half inches of the fistula. A strong handled threaded curved needle was then passed, first within the split edge of the fistula on one side, and then within that of the other side. This was done in three places, and all the stitches then tied, first those of the vaginal fistula, then those around the new anus. All that remained to be done was the insertion of numerous superficial stitches in the perineum and behind the new anus. The result was good, except the difficulty in expelling the bowel contents, that power having never been developed, but abdominal massage with aperients have produced an improvement and it is probable that the muscular power will develop and she may be able to have natural evacuations without any aid. —*Lancet*, Feb., 1894, pg. 403.

[The operator is certainly to be congratulated upon the carefully studied method of operation as well as the excellent result —Ed.]

CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE ANNALS OF GYNÆCOLOGY AND PÆDIATRY,

for February. Dr. Richard C. Norris reports

A Case of Symphysiotomy.

The pelvic measurements of the patient were as follows:

Inter-spinous	19½ cm.
Inter-crestal	20½ cm.
Diagonal	19 cm.
Circumference	70 cm
External conjugate	16 cm.
Inter-trochanteric	27 cm.
Diagonal conjugate	9 cm., scant.
Estimated conjugate	7 cm., scant.

After repairing the vaginal and perineal lacerations, the index finger was inserted in the abdominal wound, and the anterior wall was pushed back as the cut surfaces of the symphysis were allowed to come together. The abdominal wound was then closed with silkworm-gut sutures, and the usual firm binder applied around the pelvis. The diameters of the child's head were as follows:

Bitemporal	8 cm.
Biparietal	9¼ cm.
Occipito mental	14½ cm.
Occipito-frontal	12 cm.
Trachelobregmatic	9¾ cm.
Occipito-frontal circumference	32 cm.

The child, a female weighed eight pounds, was still born.

The patient's convalescence was uneventful until the third day, when cystitis developed, followed by incontinence of urine, which contained an abundance of pus and numerous tube casts. The patient had been catheterized, without any special care as to chemical cleanliness, by one of the physicians who saw her before the author's visit. She also required catheterization after delivery.

The cystitis under appropriate treatment gradually improved, and at the time of discharge from the hospital there was no incontinence of urine and only a small amount of pus. On the fifteenth day the patient developed mania; beginning as a condition of mild hilarity with irrepressible loquacity. The highest temperature during her five week's stay at the hospital was 101°, the average being 99° Her weight upon leaving the hospital was seventy-six pounds; her height, five feet three inches.

The points of interest in the case are:

(1) The prolonged labor, about ninety hours, which is believed to be the longest period of labor in any case upon which symphysiotomy has been performed in America.

(2) The difficulty in accurate estimation of the conjugata vera in any case of flat pelvis, a difficulty, the author believes, more readily overcome by Hirst's modification of Skutch's pelvimeter than by any other means at our disposal.

(3) The degree of separation at the pubic joint, which was not more than one inch.

(4) The prompt appearance of cystitis following the use of an unclean catheter in a bladder which had been subjected to prolonged compression and perhaps contusion.

(5) The development of so-called puerperal insanity.

Dr. George J. Engelmann contributes a paper on

Vaginal Hysterectomy,

considering especially hysterectomy by morcellement and the vaginal route in certain pelvic operations in place of laparotomy or the abdominal method. In opposition to his formerly expressed opinion, he now says that in cases which can often not be completed by the laparotomy, when inflammation has preceded, when suppurative salpingo-ovaritis and peritonitis complicates the case, when extensive adhesions exist, that the vaginal operation is indicated; and in extreme cases, in purulent bilateral salpingo-ovaritis with adhesions, matting together of intestines and omentum, and multiple pus centres, the vaginal route is preferable if not imperative, and abdominal section is relegated to simple non-adherent cases, admissible in suppurative forms only if unilateral or if distinct enucleable centres exist.

The vaginal method takes the place of cœliotomy for the following operations on the pelvic viscera:

(1) Hysterectomy proper for malignant disease of the uterus, carcinomatous, sarcomatous, or adenomatous; for benign tumors, fibromata and myomata, not extending above the navel; painful metritis or hemorrhagic endometritis resisting treatment; for otherwise ungovernable cases of prolapse or inversion. These are now generally-accepted operations. The novel features are:

(2) Hysterectomy for bilateral suppurative disease of the appendages, with accompanying disease of the uterus.

(3) All forms of pelvic suppuration and inflammatory deposits.

(4) Removal of the diseased appendages of one side only.

(5) For minor operations, the breaking up of adhesions, replacing and fixation of the uterus, and for purposes of examination.

The advantages of the vaginal route for all pelvic operations to which it is applicable are: the proximity of the parts to the hand of the operator; the possibility of controlling the work of knife and sciassors by the eye; the rapidity of operation, which is made by the absence of ligature or suture; the absence of hemorrhage by the application of forci-pressure before section; the avoidance of the peritoneal cavity proper to a more or less marked extent. To this he mainly attributes the absence from shock which is claimed for these operations. No visible cicatrix is left, and the possibity of ventral hernia, which is not infrequent after the abdominal operation, is avoided. Injuries to the viscera can be as readily remedied as during operation by the abdominal incision, but they rarely occur, as the intestines are not likely to come into view.

The one objection is the necessarily small field of operation, the smallness of the opening, which would limit the opportunities for this method were it not for the possibility of *morcellement*, which admits of the successful removal of large fibroid tumors extending as high as the umbilicus, or of fibroid tumors and inflammatory masses almost filling the pelvic cavity.

The vaginal operation appears to the author as the operation of choice in cases of extensive inflammation and suppuration, and whenever practicable it should be resorted to, by reason of its simplicity and rapidity and on account of the avoidance of the abdominal cavity. The very adhesions which form an obstruction in our efforts to reach the pelvic viscera by abdominal incision, the matting together of intestines and omentum, are a protecting guard against that dangerous cavity in operations by the vaginal route.

Hysterectomy by *morcellement* also affords a far greater probability for a cure for pyosalpinx of gonorrhœal origin, a cure which would appear probable or possible only by this method of operation, because it admits of, if it does not necessitate, the removal of the uterus as well, and he believes that removal of that organ in these cases is a necessity, that the imperfect results which accompany so many of the so-called successful operations for pyosalpinx and pelvic suppuration by the abdominal incision are due to the leaving of the uterine body; within the uterine mucosa and the remnants of the tubes is left the nidus of disease, and a cure, a restoration to health by the mere removal of the larger pus centres is improbable.

The method of performing the operation, its technique, the instruments required and the after-treatment of the patient are all described by the author.

Dr. Charles P. Noble discusses

Procidentia Uteri.

Among the causes of the condition he gives tight lacing, from its interference with the proper position and motion of the viscera; the loss of pelvic adipose tissue from some sudden wasting disease or at the time of the menopause. Retro-displacement of the uterus and increase in its size and weight are also given as causes, though in his experience by far the most common is laceration of the pelvic floor, especially lacerations involving the levator ani muscle and pelvic fascia. In regard to the treatment, he advises immediate restoration of a torn perineum following labor. He believes that the practice of putting in two or three sutures from the skin perineum cannot be too strongly condemned, because all severe lacerations extend two or three inches up one or both sulci of the vagina, and cannot be reached by sutures introduced from the skin perineum.

In those cases complicated by supra-vaginal elongation of the cervix he operates by doing a high amputation of the cervix, anterior colporrhaphy, and Emmet's perineorrhaphy. In operating upon the pelvic floor, the upper sutures are of catgut and the lower ones of silk, thereby obviating the necessity of removing the upper sutures, which embrace only the cut vaginal walls, and which are used only to help in narrowing the vagina. Silk is used in suturing the torn ends of the muscles and for the external sutures. The ones in the skin are removed in a week, those in the vagina after two weeks. He believes that it is wise to treat patients having procidentia for some weeks prior to their operation. The uterus should be reposited and kept in position by means of tampons.

In regard to the use of the pessary for procidentia he says: "Excepting those rare cases in which the procidentia has occurred in spite of the fact that the pelvic floor is intact, the use of the pessary for this condition is clearly illogical. A pessary can never restore a torn pelvic floor; and if this accident has been the cause of the procidentia, any treatment except the repairing of the injury is clearly illogical, and can be only of temporary value. The pessary is a useful instrument in the treatment of slight descensus and of retroflexion of the uterus when the pelvic floor is intact. The pessary should be supported from below, partly by the vagina itself and largely by the encircling slips of the levator muscle. It should never get its support from the pelvic bones, which is what happens when a large pessary is introduced to hold up a procidentia when the pelvic floor is widely torn. Used under these circumstances, a pessary must be large in order to be retained, and when it is large it invariably presses against the pubic bones. It is only necessary to point out how illogical this use of the pessary is in order that its application may be condemned."

Dr. J. T. Wilson discusses the question

Does Gonorrhœa in the Female Invariably Prevent Conception?

in a short but interesting paper. After reporting several cases in which the patient became pregnant atter undoubted infection he says:

"That gonorrhœa does frequently prevent conception is probably well established, but I do not think it is by any means a universal rule. Clinical illustrations are too many to the contrary.

If Nœgerrath's statements were literally true, sterile women and fruitless marriages would be far more common and the increase in the race would be greatly lessened, for these are a surprisingly large percentage of men, judging from my experience, who, if they confessed the truth, have suffered at some time in their lives with gonorrhœa."

Dr. Robert P. Harris contributes a description of "The First American Symphysiotomy," which he claims was performed by Dr. William Thomas Coggin, now of Athens, Georgia, who operated in Freedman, Northeast Alabama, on March 12, 1892, more than six months before Professor Charles Jewett, of Brooklyn. The operation was an entire success. The remaining paper in this issue is "Nephro-Lithiasis" by Dr. A. H. Cordier.

THE BROOKLYN MEDICAL JOURNAL

for March. Dr. James P. Warbasse writes on the

Etiology of Carcinoma.

The author does not believe in the bacterial origin of this disease, and giving the history of a number of theories of such origin, shows that the organisms found by their originators are also found in other growths, and so cannot be specific. Also, since other ptomaines give reactions in these growths, the author does not regard the poisonous watery extract "cancroin," of Adamkiewicz, as proving specific antagonism, as tuberculin does in tuberculosis.

The theory the author upholds is that for some unknown cause the epithelial cells of an organ undergo malignant change, and while still partaking of the peculiarities of form, function, etc., of the organ primarily affected, they migrate and form new malignant growths, the cells of which carry on a perverted function resembling that of the organ first diseased. In proof of this theory, the author quotes secondary post peritoneal nodules, the cells of which were similar to the cells of the liver, primarily affected, and states that the fluid exuding responded to the tests for bile; also metastatic growths in bone, presenting alveoli and colloid material, resembling the thyroid gland where the primary growth existed.

Dr. Frederic A. Cook (Surgeon to the Peary Arctic Expedition) describes

Gynecology Among the Eskimos.

He came in contact with a tribe of about two hundred and fifty persons, known as the Arctic Highlanders, living on the Northwestern Shore of Greenland. These are probably living farther north than any other human beings in this region, and are closely confined to the territory they occupy by the peculiar situation of the country. The temperature for nine months in the year is about 20° to 50° below zero. These people, the author states, live entirely on the flesh of animals and birds, and use no salt.

Girls are married at twelve or thirteen years of age, but do not menstruate until nineteen or twenty, and do not menstruate at all during the long arctic night, four months long in this region, and look forward to the return of sunlight and menstruation to cure any disease that may spring up at this time. The average is three children in every family, and a woman who proves sterile may be cast off by her husband, and pass on to another, until finally the birth of a child becomes a bond of marriage. Very few, the author states, prove sterile.

When about to give birth to a child a woman is put in a stone house, or, if this be not obtainable, in a snow hut, or in summer in a skin tent, absolutely alone. She is given food enough to last two or three weeks, and she gives herself any attention she may. The cord is cut by grinding between pieces of stone, and is tied with sinews.

After the cries of the child have been heard by those outside for about a week the house is opened, and visits are received from female friends. The mother is considered unclean for some time, and men will not enter the house.

Death is a common result of this peculiar custom. Abortions are very rare, and the victim of one is an object of ridicule. Children are nursed by the mothers for five or six years. Diseases of children are few, and mortality among children is small. Measles is not a common disease, but is fatal when it appears. Rheumatism and consequent heart troubles are about all the adults suffer from.

A little farther south the unfortunate effects of civilization are seen; contact with missionaries has led to better care of mothers and children, but also to the use of civilized clothing, whiskey, coffee, tobacco, tea and sugar, all unsuited to Eskimo manners of life.

Two-thirds of these people are thought to be tuberculous, while not one case was known in the northern district, and Grippe, which was very trifling in the north, is very fatal in the southern region.

A profouse blood supply, the author says, leads to continuous bleeding from the most trifling abrasions, when white men in this region seem to have the blood driven from the surface by the cold. Another interesting pecularity is the presence of a layer of blubber beneath the skin in all parts of the body.

Pictures of animals, people, etc., shown these people were held upside down, and sketches of animals made by them were made in the same way; but those who had been among the missionaries had lost this habit. This coincides with the theory of the inverted retinal image being mentally reversed, as a result of education.

During an interesting discussion which followed, the author declared that of forty-one or forty-two women, he was able to find only two or three with thoracic respirations. Syphilis is unknown among those who have had no contact with white people, but universal among the others. Sexual intercourse seemed only to take place during the period of sunlight, as at the approach of night the people lost strength, and became chloroanæmic, and the slightest exertion of any kind was fatigueing. This exhaustion in the absence of sunlight was felt by the exploring party also, and led to a condition of great depression.

Dr. T. S. Lawrence writes about iodide of lime as a specific in membranous croup. He distinguishes between light-colored iodide of calcium, which he had no success with, and dark iodide of lime, which he finds of great value. Ten grains of the drug are dissolved in four ounces of water, and one or two teaspoonfull given every fifteen, thirty or sixty minutes, until the cough becomes moist. He mentions quebracho as a drug that enables red-blood corpuscles to absorb more oxygen than the usual supply from a given volume of air. He used five-drop doses of the fluid extract every three hours for a child eighteen month old.

Dr. George Dederic Holston contributes an article describing

Neurotic (Reflex) Eczema.

The author says although this disease is unquestionably eczema (a catarrhal inflammation of the skin) yet it differs from ordinary eczema in clinical appearance, etiology and treatment.

It occurs at all ages, but is most frequent under two years of age. Location, symmetry, tendency to sudden remission or aggravation, and rebelliousness to external treatment distinguish this from ordinary eczema.

In children the most frequent sites are the face or scalp, in whole or part, the upper extremities, confined to the extensor surfaces, deltoid, etc. Individual patches are sharply defined, circular, elliptical, or ovoid; and while resembling zoster, they group at the termination or decussation of nerves, instead of along their course.

All the appearances of ordinary eczema are seen, and the patches usually show vesicles. It differs from ordinary eczema in affecting the cheeks and extremities symmetrically.

Cases are cited to show the effect of hygiene, regulation of diet, bowels, etc., also the relief of adherent prepuce, or any kind of genital irritation, and the uselessness of local treatment without this.

Nervous sedatives may be required, in some cases ergot is very useful, and often the itching is so great as to call for salicylic acid, and menthol, ichthyol, carbolic acid, etc. Counter irritation to the neck or over the spine sometimes gives a marvelously sudden remission.

PERISCOPE.

IN CHARGE OF WM. E. FARKE, A.M., M. D.

MEDICINE.

Acute Tonsillitis.

Dr. C. Edwin Miles says, in the Massachusetts *Medical Journal:* "If the pultaceous deposits develop on the tonsils or fauces, I find no remedy to surpass the following:—

℞ Ol. eucalyptus glob. ..... mxv
Spt. camphor 3iss
Tinct. guaiac. 3iiss
Glycerin ..... q. s. ad 3j

M. Sig. : Put 10 drops on a bit of sugar and allow it to dissolve in the mouth, every hour or two."

Irrigation of the Stomach in the Treatment of Obstinate Hiccough.

Dr. Gallant in *Med. Week.* The author describes a case of presistent hiccough in which this unpleasant symptom occured at intervals of one or two minutes and lasted for three days. During sleep no singultus occurred. Temporary relief was obtained by the administration of the hydrochlorate of cocaine gr. 1-10 every 3 hours, followed later by 1-12 gr. doses of hydrodchlorate of pilocarpine three times daily. The hiccough reappeared and was more pronounced. Suspecting it to be of gastric origin Dr. Gallant washed out the stomach; immediate relief was afforded and the spasm promptly disappeared. A second case of obstinate hiccough which resisted chloral, opiates, ether and bromides responded to catheterization of the bladder which was distended and relief temporarily obtained for about 8 hours. Lavage of the stomach caused an entire cessation of hiccough in this case also. Gastric irrigation being a simple and harmless procedure, it ought to be resorted to in every case of obstinate hiccough whether of gastric origin or due to nervous irritation. In nervous hiccough favorable effects ought to be produced by diminishing the reflex irritability of the nervous system as was shown by passing a catheter in the case above described.

Ice in Acute Pneumonia.

Prof. Mays urges the value of this treatment. He has the chest on the front side and back of the area affected surrounded with rubber bags filled with ice. The number of these depends on the size of the area involved. They are allowed to remain until the temperature becomes nearly normal. If a new portion of the lung is involved, the ice bags are removed to this spot, and this is continued until the tendency to extension ceases. —*Philadelphia Polyclinic.*

Antipyrin as a Hemostatic and a Antigalactagogue.

Dr. J. S. Davis depends on antipyrin as a local hemostatic. Its effects are prompt and lasting. There is no clot to interfere with primary union, and it is in every respect the ideal hemostatic. When possible the powder is sprinkled over the bleeding surfaces and covered with borated gauze. When this method cannot be pursued a fifty per-cent. solution is injected.

By giving it in doses of four grains, every two hours, the lacteal secretion will be suppressed in from two to six days without any change of diet. He has never found it necers sary to continue the treatment longer than four days.—*Medical Review.*

Treatment of Intestinal Hemorrhage in Enteric Fever.

James W. Allen, M. B., says: The first indication is stillness on the part of the patient. Soda water and milk, sherry whey and (if the patient is very weak) a little brandy and water—all iced—may be given at reasonable intervals. Of course free stimulation is out of the question. The patient may be permitted to suck or swallow small pieces of ice. Large draughts of fluid should be

avoided. If the hemorrhage is considerable in amount the external application of cold to the abdomen is one of the first remedies which ought to be employed. This should be done with a Zeiters' apparatus, or similar arrangement, and not with heavy and leaky bags. It is better to employ the external application of cold in an intermittent than a constant manner, for example use it an hour and omit it an hour. In addition to above methods of application of cold it may sometimes be advisable to introduce pieces of ice into the rectum.

In regard to the use of drugs the author speaks of three which he has used. These are: 1. Lead and opium combined in pill; (2) Turpentine; (3) Liquid extract of ergot named in the order of their merit.

A Word for the Sleepless.

Dr. J. E. Huxley of Maidstone, Eng., thinks he has hit upon the natural remedy for sleeplessness. It is in brief to curl under the clothes like a kitten or put the head under the wings like a hen. His detailed description of the technique is given in a letter to the *Medical Press and Circular*, when he says: This insomnia seems now to be a universal affliction. We live wrongly; sit up late and overwork the brain and thus go to bed in an excited condition. No one seems to have hit upon the natural remedy. I think I have. People take chloral and the like at their peril, and a fatal consequence not seldom ensues. It is all wrong, for you cannot control the dose required for the exact circumstances. But try natures plan instead—lower the supply of oxygen to the blood, produce a little asphyxia, limit the quantity of air to the lungs, and the heart and circulation becoming quicker, the brain loses its stimulant and sleep follows. When you find yourself in for a sleepless night, cover your head with the bedclothes and breathe and rebreathe only the respired air. Thus you may reduce the stimulating oxygen and fall asleep. There is no danger. When asleep you are sure to disturb the coverings and get as much fresh air as you require, or when once drowsiness has been produced, it is easy to go on sleeping though the air be fresh. What do the cat and dog do when they prepare to sleep? They turn round (generally three times) and lastly bury their noses in some soft hollow in their hair or fur and "off" they go. They are in no danger, although it might look as if they were from the closeness with which they imbed their noses.—*Med. Rec.*

Calomel as an Antipyrtic.

Drs. R. J. Nunn and A. B. Simmons, of Savannah, Ga., in the paper prepared for the Section of Therapeutics (First Pan-American Medical Congress) remark: From the use of calomel in twenty-five cases of typhoid and continued fever cases we have drawn the following conclusions:

1. Calomel is a sure and safe antipyretic, reducing the temperature from two to three degrees in a few hours.
2. Small doses will prove of no avail.
3. The ingestion of large doses was followed by no untoward event, no ptyalism, no hyper-catharsis. This is contrary to the usual opinion.
4. Diarrhœa, hæmorrhage, albuminuria, tympanites have not been contra-indications to the use of the remedy.
5. The reduction of temperature occurs without cathartic action on the bowels.
6. The Calomel acts best in combination with soda, bismuth and pepsin.
7. In some instances, the remedy appeared to cut short an attack, and in others, while having no influence on its duration, it modified all symptoms, and by keeping temperature in check, aided materially in the management of the case.—*Journal American Medical Association.*

Prevention of Boils.

Dr. Roensbach (*Munch. Med. Wochenschr.*) in order to prevent the development of crops of boils, in the back of the neck and nose, especially advises persistently rubbing the region attacked with some fatty substance, as cold cream, lanoline, unsalted butter or lard. Lanoline, above all is to be preferred. The development of boils is due to dryness of the skin, and by inunction of a fatty substance the dryness is removed and the penetration of micro-organisms prevented.—*Ex.*

Chronic Bronchitis, Etc.

The following is a formula of the late Dr. William Thompson, who died several years ago, at Lazaretto, Philadelphia, of yellow fever:

℞
Fl. ext. tarax.....
Fl. ext. rhei.....
Syr. senega.....
Tinct. tolution.....
Sod. bicarbonat.....
ää ℥ ss.
℥ j.

M. Dr. Thompson prescribed this for a patient who had chronic bronchitis, acid dyspepsia, etc, with good effect, in doses of one teaspoonful three or four times daily

REFRIGERANT, SEDATIVE AND EXPECTORANT.

℞
Cit. potass. liq.....℥ iij.
Spir. nit. dulc.....℥ iij.
Tinct. lobelia.....℥ ij,
Oxy. scilla.....℥ v.
Syr. simp .....℥ ij

M. Sig. Teaspoonful pro ren ata.

The above was prescribed by the late Dr. Condie. A very efficient remedy, rather in advance of its time.—*Buckley Medical Summary.*

A New Treatment for Pertussis.

Sidney B. Straley reports the results of the use of thymus serpyllum in pertussis. He used a tincture made from the green drug. His conclusions are:

1. Thymus serpyllum is a specific for pertussis.

2. It acts in any stage of the disease.
3. It also is a nerve sedative and gastric stimulant.
4. It is necessary to use the green plant.
5. It is perfectly harmless in doses as large as a teaspoonful of the tincture for a child of eight years.
6. The action is fully established in twenty-four hours and completed in five days.
7. Lastly: indications are that there will be no recurrence subsequently, at least not more often than in cases which run the full course.—*American Doctor.*

Tuberculosis.

℞ Iodoformi..... gr. 20-40
Ess. eucalypti.....
Ess. terebinthinae .....
Ess. guaiaci.....
Creasoti..... ..... āā fl ℥j

M. Sig. By inhalation or spray of from five drops upward.

—*Ex*

Importance Attached to the Condition of the Tonsil.

The author calls attention to the prominence given the tonsils by the act of gagging, which forces them forward and toward the median line, cutting off the view of all that lies beyond. Moreover, the difficulty of posterior rhinoscopy and the mystery surrounding the function of the tonsil all unite to direct the physician's attention to these little bodies. The examination of the tonsils should be conducted while they are in repose, so that any changes in the adjoining tissues may be recognized and properly treated. The author shows that the symptoms usually ascribed to large tonsils may likewise be due to the other causes (adenoid disease, etc.), and he would have these eliminated before resorting to tonsillotomy.

In conclusion, he presents the following summary:

1. Because the tonsils are easier to see than the nose and post-nasal space, is no sign that they are more important than the latter.
2. Form no estimate of the size of the tonsil unless you see them in repose.
3. Always examine the back teeth and the base of the tongue.
4. In acute follicular disease of the tonsils, look for and treat disease of the other follicular tissues in the throat.
5. Nasal obstruction, cough, and impaired voice are much more likely to be due to nasal or post-nasal hypertrophy than to tonsillar hypertrophy.
6. The fact that the tonsils are enlarged or diseased should lead us to look for a possible explanation in the parts higher up.
7. Free the nose and post-nasal space in addition to, or instead of, tonsillotomy, if you wish to improve the voice and respiration.

Jaundice.

In jaundice, due to exposure to cold, which has brought on a slight hepatic congestion, Prof. Hare says that in a large number of cases colomel given in ⅛ of a grain doses until ½ of a grain has been taken will be found to give relief.—*C. and C. Rec.*

Cardiac Tonic.

Dr. Edward C. Mann, of Brooklyn, N. Y., in the *Physician and Surgeon* gives the following formula:

℞ Caffein. hydrochlor.,..... ℥ iss.
Strychniæ sulph.,..... ..... gr j.
Ext. belladonnae,..... gr. iss.
Fel bovis insp.,..... ℥ j.
Ext. colocynth. comp.,
Ext. aloes, ... aa gr. xxx.
Ext. taraxaci,..... gr. 45.

M. et fiant pil. No. xxx. Sig. One three times a day.

—*The Medical Bulletin.*

Intestinal Fluxes.

Dr. J. Zach. Taylor advises:

℞ Pulv. opii,
Pulv. plumb. acetat.,
Camphor-gum..... aa gr. xxx.
Ext. capsicum fl ,..... ..... gtt. x.
Beech-wood creasote,..... gtt. v.
Alcohol, q. s. to dissolve camphor.

M. ft. pil. No. xxx.
Sig. One to six pills daily, according to urgency of case.

—*St. Louis Courier of Medicine.*

Removal of Warts.

For the removal of warts, Dr. R. B. Morrison, of Baltimore, Md., prescribes the following:

℞ Hydrarg. bichlor.,... .... gr. v.
Acid. salicyl.,.....℥j.
Collodion, ...℥j.

He sometimes increases the bichloride of mercury to thirty grains in the same quantity of collodion, if the milder application does not answer. It is applied every day once, the upper crust of the previous application being removed before a fresh one is made. Four such applications generally softened the wart to such a degree that gentle friction removes it plainlessly, the further dressing being any simple ointment.—*Ex.*

Tubercular Cystitis.

℞ Ext. belladonn.,
Ext. oppii,..... aa gr. ½.
Iodoform,..... gr. ¾.
Cerae,..... gr. xv.
Ol. theobrom.,..... gr. 45.

M. ft. suppos. No. j.

—*La. Medicine Moderne*

Infantile Convulsions.

Infantile convulsions are treated by Dr. Jule Simon with the following:

℞ Chloral hydrat.,
Potass. bromid.,..... ..... aa gr. xv.
Syr. codein,..... gtt. x.
Tinct. moschi,
Tinct. aconiti rad.,..... aa gtt. x.
Aq. aurant. flor.,..... ad ℥ij.

M. Sig. Teaspoonful doses, or by enema if it cannot be taken by the mouth.

—*El. Sigo. Medico.*

Constitutional Syphilis.

A mixture often ordered in constitutional syphilis by Dr. Keyes is as follows.—(*Cincinnati Lancet-Clinic*):

℞ Potass. iodid.....ʒij
Ammonii carbonatis.....ʒss
Tinct. cinchonae comp.....ʒiv
Syr. aurantii cort.....ʒiss
Glycerini.....ʒj
M Sig. A teaspoonful, well diluted, after each meal.

—*The Coll. and Clin. Record.*

Painful Pharyngitis.

℞ Sulphate of morphine.....gr. iv
Phenic acid.....
Tannin.....āā ʒss
Glycerine.....
Water.....āā ʒiv
Paint the throat two or three times daily.

—*Eng. Med. Press.*

Cardiac Palpitations in Neurasthenics.

Th. Zerner employs the following mixture:

℞ Iron pyrophosphate.....
Zinc bromide.....āā gr. 54
Digitalin tincture.....fl ʒss
Ergotin.....ʒiij
Orange flower-syr.....fl ʒvj
Dist. water.....fl ʒiij½
One to three teaspoonfuls daily.

—*Amer. Med. and Surg. Bulletin.*

Myalgia

℞ Liniment chloroformi.....
Liniment aconiti.....āā fl ʒiv
Tinct. opii.....fl ʒiij
Liniment saponis.....ad. fl ʒiv
M. Ft. liniment. Sig. To be well rubbed into the painful parts.

—*The Practitioner.*

Irritable Cough.

℞ Acidi hydrocyanici diluti.....ʒiss
Morphinae acetatis.....gr. iss
Mucilaginis acaciae.....ʒj
Syrupi pruni Virginianae.....ʒiv
Aq., ad.....ʒvj
M. et fiat mistura. Sig. A teaspoonful to be sipped every four or six hours.

—*The Practitioner.*

WHY, OF COURSE.—*Stivitts*: "The German investigators are experts in bacillus hunting, aren't they?"

Whiffett: "Well, wouldn't you naturally expert a germ. man to cholera microbe?"

SURGERY.

New Operation for Prolapse of the Uterus

Freund (*Centralbatt fur Gyn.*) proposes simply to narrow the vagina to any desired extent by encircling it with a series of permanent sutures, which begin just below the utero-vaginal junction and are placed one after another down to the external orifice. Freund has used for the suture material, silver-wire, but Edebohls, who has tried the operation, and recommends it, (*Medical Record*) prefers to employ silkworm-gut.

A New Treatment of Naso-Pharyngeal Catarrh.

Bates (*Med. News*) has treated with benefit more than fifty patients by syringing the lachrymal sac and nasal duct. Of the remedies used, olive oil gave the most general satisfaction. The syringe used is the ordinary eye dropper, with a tube drawn out to a fine point, bent at an angle of 60°, and about one-quarter of an inch long. It is small enough to enter the smallest punctum, and tapers so abruptly that it closes the largest punctum, preventing a return flow of the fluid.

To make the injection, the operator sits in front of the patient. Artificial light from an argand burner is reflected by the forehead-mirror on the inner side of the eye, direct illumination being less satisfactory. The operator may also stand behind the patient, who is then directed to look upward and outward. A piece of cotton about one-fourth of an inch in diameter is placed over the semilunar fold and held with the forefinger of the left hand with slight pressure against the upper punctum; this prevents the fluid from entering the eye from the punctum of the upper lid. The thumb of the left hand everts the lower lid sufficiently to expose the punctum.

The syringe, partly filled with the fluid to be injected, is lightly held by the bulb with the thumb and first two fingers of the right hand, the tip is inserted into the punctum and the syringe turned until the tip is at right angles to the margin of the lid and parallel to the conjunctival surface of the lower lid. Slight pressure is made on the bulb, and the level of the fluid in the syringe is seen to descend as the injection is being made.

Sometimes the injection is difficult, after the tip is introduced into the punctum; and, manipulation of the syringe up, down and in various directions, will be required to free the point from obstructing conjunctival fold. Nervous patients give trouble, and in such cocaine helps, but does not always relieve the difficulty.

How to Cut Short Paroxysms of Whooping Cough and Some Neuralgias of the Trigeminal nerve.

. Maegely (*Mercridi Med.*) Lift the hyoid bone and larynx by the thumbs applied under the greater cornua, the index fingers being kept on the ears and the other fingers on the neck. The duration of this procedure should be from a minute to a minute and a half. The author claims for his method certain cessation of the paroxysms of pertusses and relief in trigeminal neuralgia, hemicrania and globus hystericus. It is probably a phenomena of reflex inhibiation. Occasionally several attempts are required.

Viburum for Treatment of Abortion.

Polak advises rest in bed. Morphine or opium per rectum and drachm doses of the fluid extract of viburum, or four-grain doses of the solid

extract in pills. Of thirty-two cases treated in this way, none resulted in miscarriage.—*New York Journal of Gynecology and Obstetrics.*

The Treatment of Cholera.

By H. Rosahuksy, M. D. The following preparation has been used by me with great success in the beginning of cholera where there is profuse vomiting and diarrhœa. The same preparation has been highly recommended by Professor Botkin of Russia, and it is very extensively used by the Russian physicians. This preparation goes under the name of Guttae Botkina.

℞ Tr. Chinae Comp.
Anodyn Hoffmani.....ää 15,0
Acid Miur. Dil.,..... 2.5
Ol. Meuth Pip..... 0.3
Chinini Muriatici..... 2.0

M. S. Twenty drops three or four times a day during cholera.

In cholera infantum I use this preparation in divided doses and a large proportion according to the age, or in the following manner which gives excellent results.

℞ Acid Mur. Dil..... 2.0
Liquor Anod. Hoffman..... 6.0
Bismuthi Salicyl..... 6.0
Acid Carbol, (C. P.) 0.12
Glycerine 12.0
Aq. Meuthae Pip. ..... ad. 60.0

M. S. Teaspoonful every hour, according to age.

For choleraic diarrhœa, the following preparation is also good:

℞ Tr. Opii.....4. 0
Essentiae menthae.....
Liq. anod. Hoffmani.....ää 8. 0

M. Sig. Twenty drops four or five times a day.

—*Medical Record.*

ARMY AND NAVY.

U. S. ARMY FROM FEBRUARY 25, 1894, TO MARCH 24, 1894.

Leave of absence for twenty days, to take effect upon the adjournment of the Eleventh International Medical Congress to be held at Rome, Italy, March 29 to April 5, 1894, is granted to Colonel Bernard J. D. Irwin; Assistant Surgeon General.

A Board of medical officers to consist of Major Joseph K. Corson, Surgeon; Major Walter Reed, Surgeon; Captain Julian M. Cabell, Assistant Surgeon, is by direction of the Secretary of War appointed to meet at the call of the President thereof, at the Army Medical Museum Building, in this city for the examination of First Lieutenant Philip G. Wales, Assistant Surgeon, to determine his fitness for promotion.

Lieutenant Wales will report in person to the President of the Board at such time as he may designate.

By direction of the President, the retirement from active service on the 25th of February, 1894, by operation of law of Captain George T. Beall, Medical Storekeeper, under the provisions of the act of Congress, approved June 30, 1882, is announced.

The leave of absence granted Captain Reuben L. Robertson, Assisstant-Surgeon, United States Army is extended one month.

Major John Brooke, Surgeon United States Army, retired from active service, February 22, 1894.

First Lieutenant Ashton B. Heyl, Assistant Surgeon, retired from duty at Fort Nichvava, Neb., ordered to Columbus Barracks, Ohio, for duty at that depot, on the arrival of Lieutenant Thomas S. Bratton, Assistant Surgeon, at Fort Niobvava, Neb.

NEWS AND MISCELLANY.

Acting Assistant Surgeons.

In the house of representatives, February 16, 1894, Mr. Richards introduced a bill to remove certain disabilities of the late acting assistant surgeons.

WHEREAS before, during, and since the war of eighteen hundred and sixty-one to eighteen hundred and sixty-five, but chiefly during the war, private physicians were employed as medical officers serving under the orders of their superior officers, as such, agreeably to Army regulations, in the armies of the United States, in addition to the commissioned medical staff, because the number of the latter was not sufficient for the necessities of the service. This class of officers was known officially as acting assistant surgeons, because they performed exactly the same duties, and were subject to the same control as commissioned medical officers. These acting assistant surgeons were employed under contract made in accordance with paragraph twelve hundred and sixty-eight, Revised Regulations of the United States Army, eighteen hundred and sixty-one, and paragraphs thirteen hundred and four and seventy-one, Appendix B, Revised Regulations, eighteen hundred and sixty-three, and were obliged to remain in the service of the United States for a stated time. Among these officers were many of the eminent physicians and surgeons of the United States. Some of the duties performed by acting assistant surgeons were as follows: They were in charge and command of United States military hospitals, known as general, division, field, and post hospitals: they had charge and command of United States military hospitals for the care of contagious disease; they were in command or in charge of hospital trains, hospital boats, and ambulance trains, and were excecutive officers of United States general hospitals; they acted as brigade and regimental surgeons and at least one acting assistant surgeon acted as medical director of a department for nearly a year; they were responsible for hospital funds and property, and also post funds; they served on court-martial, which the Articles of War require shall be composed of officers, and also on

boards of surveying, in camp, field, and garrison, on overland expeditions, and in Indian wars; they faced death and endured hardships like commissioned officers, and it is known that nearly one hundred and fifty died in the military service of the United States; and

WHEREAS these acting assistant surgeons were allowed fuel, rations, quarters, and transportation in kind, and to purchase rations from the commissary, and traveling expenses the same as commissioned medical officers with rank of first lieutanant and were accorded, by order of the War Department, the same protection in their position, the same respectful subordinate conduct, and the same military courtesy from enlisted men as if they were comissioned officers, because they were placed in the position of comissioned officers so far as related to their duties. Many of them were also required to wear the uniform of an assistant surgeon. Acting assistant surgeons who were disabled by reason of disease contracted or injury received in the military service have been granted pensions under a law which assimilates them to the rank of first lieutenant of the military or Marine Corps; and

WHEREAS because they were not commissioned as officers, but were employed by contract as such, they are denied admission to military organizations like the Loyal Legion and the Grand Army of the Republic; and to relieve this unjust discrimination, and to give a proper recognition to their patriotism, duties, responsibilities, services, hardships, and exposures, they ought to be entitled to receive the rank for which they are allowed pensions and which will relieve them from these disadvantages. The appended bill is offered for this purpose. It involves no expense to the United States Government and no change in the relative rank of officers of the medical corps of the United States Army who have been or are now in the service of the United States; Therefore,

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That private physicians who were employed as medical officers in the armies of the United States for a period of not less than three months, in accordance with paragraph twelve hundred and sixty-eight of the Revised Regulations, United States Army, eighteen hundred and sixty-one, and paragraphs thirteen hundred and four and seventy-one, Appendix B, Revised Regulations, eighteen hundred and sixty-three, and who were known officially as acting assistant surgeons of the United States Army, and whose services were honorably terminated, shall be commissioned by the President of the United States as acting assistant surgeons of the United States Army; and the date of employment as acting assistant surgeons to be the date of commission and muster into service, and the date of the honorable termination of service as acting assistant surgeons to be the date of discharge or muster out of service: *Provided*, That no pay or allowance shall be made to any such acting assistant surgeon by virtue of this act; and this act shall not affect the rank, pay, or emoluments of commissioned medical officers of the United States Army.

Cigarette Smoking.

We are glad to see a campaign inaugurated against the cigarette smoking curse; and we are pleased that the daily press is lending its assistance in educating parents to the evil of this terrible habit. It is also gratifying to find that so many clergymen, physicians and school teachers are doing good work in depicting the moral depravity and the physical degradation, that are sure to overtake the youngster who contracts and persists in the habit of cigarette smoking. We beg leave, however, to remind these workers in the good causes who are so ably and eloquently denouncing this most injurious habit, that no preacher is so eloquent and effective as he who practices what he preaches. Let the man with a cigar in his mouth (and several more in his pocket) explain to the small boy the evil consequences of smoking cigarettes, and he is likely to be met with the query—"What are you giv'n us;" the urchin cannot understand that a small cigarette can hurt a small boy if a large cigar does not hurt a large man. "Consistency thou art a jewel." "If eating meat causes my brother to offend, I will eat no meat."—*Ex.*

The Old Story.

A correspondent of an English contemporary, writing from a small manufacturing town, says that the number of practitioners has risen there within four years from four to eight. The population in the meantime had not increased. As an evidence of how the doctors were prospering, three children of one of them were working in the factory. —*Ex.*